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HIV/AIDS IN PRISONS:

Final Report of The Expert Committee on AIDS and Prisons

Canada

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Final Report of The Expert Committee on AIDS and Prisons

February 1994

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21 January, 1994

Mr. John Edwards
Commissioner
Correctional Service Canada
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Dear Commissioner Edwards:

In June 1992, the Solicitor General of Canada announced that an expert committee would assist the federal government to promote the health of federal inmates and to protect Correctional Service of Canada staff, and to prevent the transmission of human immunodeficiency virus (HIV) and other infections within federal correctional facilities.

The Expert Committee on AIDS and Prisons has reviewed laws and policies, solicited broad input from within and outside Canada, visited correctional facilities and met with inmates, staff and interested bodies, presented its findings at meetings and conferences, and prepared a *Working Paper* of the Expert Committee on AIDS and Prisons that has been distributed widely. The Committee was impressed by and gratefully acknowledges the interest, commitment and help it has received from inmates, Correctional Service of Canada staff, experts, and the public.

HIV infection and drug use pose formidable and urgent health, social and economic challenges for correctional institutions. These problems have to be addressed, and in responding to them, it is important to do so quickly, since reducing the prevalence of HIV infection in correctional facilities, thereby reducing exposure to this virus, will protect the health of staff, inmates, and the public. Preventing the spread of HIV in correctional facilities is the most efficient way to do this. Consequently, the Committee has sought ways by which responses that are necessary in federal correctional facilities can be made possible. In doing so, the Committee has formulated recommendations and prepared a final report that contains these recommendations.

The Committee has completed its work and, now, the Committee respectfully submits to you this *Final Report* of the Expert Committee on AIDS and Prisons.

Yours sincerely,

Norbert Gilmore, Ph.D., M.D.
Chair,
Expert Committee on AIDS and Prisons

ACKNOWLEDGMENTS

The Expert Committee on AIDS and Prisons wishes to thank many people for their contributions to and support of the Committee's work.

First, the Committee wishes to thank the former Solicitor General of Canada, Mr. Doug Lewis, both for the opportunity he provided the Committee to carry out this work and for his commitment to solving the problems posed by HIV/AIDS in federal correctional institutions. The Committee gratefully acknowledges the help and support of Mr. Ole Ingstrup, former Commissioner, and Mr. John Edwards, present Commissioner of the Correctional Service of Canada.

The Committee wishes to acknowledge the contributions of the staff of the Correctional Service of Canada (CSC) and of inmates with whom the Committee met and who provided ECAP with information necessary to its work. ECAP also wishes to thank the many people and the governmental and nongovernmental organizations who responded to our solicitations and enquiries. Their input has been invaluable in identifying issues and formulating responses to them. A list of these individuals and organizations has been included in *HIV/AIDS in Prisons: Background Materials* as Appendix 9.

ECAP also wishes to acknowledge the organizations, committees and individuals who have worked on issues related to HIV/AIDS and drug use in prisons in Canada. Their dedication to resolving the issues raised by HIV/AIDS and drug use in Canadian prisons has been an inspiration and an invaluable resource for the Committee. They include Gerald Benoît, Michael Linhart and the many other inmates who have established self-help groups in federal institutions; the Canadian AIDS Society; Dr. Catherine Hankins of the Centre for AIDS Studies of the Community Health Department of the Montreal General Hospital; the National Advisory Committee on AIDS; the Ontario Regional HIV/AIDS Advisory Committee; the Parliamentary Ad Hoc Committee on AIDS; Dr. Jacques Roy and the staff of Health Care Services, Correctional Programs and Operations, CSC; the Royal Society of Canada; Xavier Sanchez Horno; Ron Shore, Cheryl White and the Kingston AIDS Project; Andréa Riesch Toepell and the John Howard Society of Metropolitan Toronto; and the Prisoners with AIDS/HIV Support Action Network (PASAN).

Three people who have worked closely with the Committee deserve special thanks. Their efforts have helped to make ECAP a success. They are: Mr. Robert Adlard, formerly of the Correctional Service of Canada and now with the Department of Justice, who was one of the Committee's observers until May 1993; Mr. Wayne Stryde, formerly of Health Canada and now with the Correctional Service of Canada, who has been one of the Committee's observers during the whole of its existence; and Ms. Margaret Gillis of Health Canada, an observer of the Committee since January 1993.

Finally, the Committee wishes to thank the following persons for their assistance: Garry Bowers for his help in editing the *Working Paper* and the *Final Report*; Glenn Betteridge for assisting in the review of Canadian and international prison policies; Patricia DiMeco for data input and Maria Hooey for consulting on the statistical analysis of the data of the staff and inmate committee questionnaires and for assisting in the writing of Appendices 5 and 6 of the *Background Materials*; the translators of the text into French at the Translation Services, Health and Criminology Section, Department of the Secretary of State, Montreal; and Jean Dussault for helping with the final review of the French translation.

ECAP'S FINAL REPORT

ECAP's *Final Report* consists of three documents: (1) *HIV/AIDS in Prisons: Final Report and Recommendations of the Expert Committee on AIDS and Prisons*; (2) *HIV/AIDS in Prisons: Summary Report and Recommendations of the Expert Committee on AIDS and Prisons*; and (3) *HIV/AIDS in Prisons: Background Materials.* The *Final Report* contains an in depth analysis of each of the 14 major issues that ECAP considered had to be addressed. The *Summary Report* summarizes the work of the Committee and contains its recommendations. The *Background Materials* provide the following appendices:

Appendix 1: Canadian Prison Policies Relating to HIV/AIDS

Appendix 2: International Prison Policies Relating to HIV/AIDS

Appendix 3: Policies of Selected Countries Relating to HIV/AIDS

Appendix 4: Canadian Case Law and Precedents

Appendix 5: Results of the Staff Questionnaire

Appendix 6: Results of the Inmate Questionnaire

Appendix 7: Jürgens R., Gilmore N. Disclosure of Offender Medical Information: A Legal and Ethical Analysis

Appendix 8: "HIV/AIDS in Prisons:" Selected Presentations Given at the Sessions on "HIV/AIDS in Prisons" at the 6th and 7th Annual British Columbia AIDS Conferences

Appendix 9: List of Submissions to ECAP and of Responses to the *Working Paper*

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INTRODUCTION

Issues raised by HIV/AIDS and by drug use in prisons have been the subject of considerable concern among prisoners, prison authorities and the public. Many of these issues are controversial, and they have elicited significant media attention, community discussion and political debate. In an effort to resolve these issues, the Expert Committee on AIDS and Prisons (ECAP) was created by the Solicitor General of Canada on 15 June 1992. The Committee's goal was to assist the federal government in promoting and protecting the health of inmates and of staff, and preventing the transmission of HIV and other infectious agents in federal correctional facilities. ECAP has consulted on, reviewed and analyzed issues raised by HIV infection, AIDS and drug use in these facilities. During 1992 and 1993, ECAP visited correctional facilities in British Columbia, Ontario and Quebec; reviewed and analyzed relevant national and international policies, reports and documentation; and solicited information and submissions from inmates, prison staff, and groups or individuals with an interest in HIV/AIDS and prisons.

As part of its work, ECAP prepared *HIV/AIDS in Prisons: A Working Paper of the Expert Committee on AIDS and Prisons*. The *Working Paper* addressed many of the issues that HIV/AIDS and drug use raise in federal correctional institutions and contained conclusions of ECAP's deliberations and suggestions for action, but no recommendations. More than 1000 copies of the *Working Paper* were distributed in Canada and internationally to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and by drug use in prisons an opportunity to review the Committee's work and proposals and to provide further input into the Committee's final report.

ECAP has received 50 responses to the *Working Paper*. Respondents have included inmates and several wardens and other staff of federal correctional institutions, and many individuals and groups working on issues raised by HIV/AIDS and by drug use in prisons, including the National Advisory Committee on AIDS (NAC-AIDS), the Canadian AIDS Society, the Prisoners with AIDS/HIV Support Action Network (PASAN), the Associate Director for HIV/AIDS at the U.S. Centers for Disease Control, the Medical Director of the U.S. Federal Bureau of Prisons, and the Deputy Director of the World Health Organization's Global Programme on AIDS. In general, ECAP's conclusions were widely supported. Some suggestions were made to improve language and content. In many cases, the formulation of recommendations in the *Final Report* reflects this input. Most controversial were ECAP's conclusions regarding ways to reduce the harms from drug use in correctional institutions. Many respondents expressed a view that ECAP did not go far enough in addressing the risks deriving from the sharing of unclean injection equipment in correctional institutions. Responses from

Correctional Service of Canada (CSC) staff, on the contrary, sometimes suggested that ECAP's conclusions went too far, and emphasized CSC's commitment to eradicate drug use in its institutions.

With only a few exceptions, responses to the *Working Paper* did not warrant a significant departure from the format and the content of the *Working Paper* and, in particular, its conclusions. In this *Final Report*, much of the text of the *Working Paper* has therefore been retained. However, the information has been updated and new material has been incorporated. In particular, relevant sections from the 1993 World Health Organization (WHO) *Guidelines on HIV Infection and AIDS in Prisons* have been included and are discussed in more detail in *HIV/AIDS in Prisons: Background Materials* as Appendix 2, "International Prison Policies Relating to HIV/AIDS." As stated by Dr. Dorothy Blake, Deputy Director of WHO's Global Programme on AIDS, who "congratulate[d] the Committee on the report and its excellent conclusions," the conclusions reached in the *Working Paper* "are in no way inconsistent with the WHO's Guidelines and we are obviously pleased to have your conclusions as a valuable resource in our advocacy work in relation to further policy on HIV in prisons."[1]

Making Necessary Changes Possible

Although members of ECAP were already familiar with many of the issues raised by infectious diseases and by drug use in Canadian correctional institutions, in the course of its work the Committee learned a great deal more about these institutions and some of the problems they face. The Committee has come to appreciate the exceedingly complex environment of correctional facilities and the problems that HIV infection, AIDS and drug use create in this particular environment. In its search for ways for the Correctional Service of Canada (CSC) to better promote and protect the health of staff and inmates and to prevent the spread of infections in penitentiaries, the Committee reached numerous conclusions. Seldom were they reached easily, but when they were reached, acceptance and support of them was unanimous. Attaining this unanimity was one of the most arduous but gratifying experiences for the Committee, and it emphasizes ECAP's commitment to what needs to be done.

ECAP often found that what needed to be done to resolve many of the problems raised by HIV/AIDS and by drug use in prisons was obvious and had in many cases already been articulated by others, but that how to implement these changes was seldom evident. As a result, ECAP focused on strategies for making necessary changes possible. ECAP's *Working Paper* and the *Final Report* reflect this approach, emphasizing not only what may be changed but how to make changes possible in federal correctional facilities.

Correctional facilities and the communities within them are not static organizations, but dynamic ones. The dynamics are exceedingly complex and not always readily apparent. They are further complicated by a variety of factors, including: (1) the sometimes divergent goals, aspirations, needs and perceptions of inmates, health-care staff, correctional officers, administration, communities outside prisons, politicians and the public; (2) the unique environment of penitentiaries; (3) the problem of constrained resources and competing demands concerning their allocation; and (4) incomplete knowledge about the prevalence and likely impact of HIV infection in penitentiaries. In such an environment, change, or even the possibility of change, often elicits strong or divisive opinions and favours entrenchment of the status quo. This applies as much to personal behaviour as to operations and social interactions. ECAP recognizes that the challenges for CSC and for both staff and inmates to implement changes in this milieu are formidable.

Many of the complex problems HIV/AIDS raises in prisons derive from what Harding has called "an underlying conflict of values between the penal system, (based on the principles of 'just desserts,'

retribution, and dissuasion), and medical care (based on promoting health and limiting suffering)."[2] Corrections is a public safety or law enforcement activity rather than a public health activity.[3] It has been found that, outside the prison setting, coercive interventions are often ineffective and may be counterproductive to the control of HIV transmission and its consequences[4] and that the most effective interventions are those based on respect for persons, their rights and dignity, and which promote and encourage personal responsibility and provide realistic opportunities for behaving safely. In prisons, however, preventing disease and delivering medical care requires reconciling or balancing a medical model based on prevention, diagnosis, care and treatment with the correctional requirements of custody and control.[5] Security concerns and the notion of punishment inherent in the prison system can be serious obstacles to effective prevention of HIV/AIDS in prisons. In this setting, populations engaging in risk-producing activities are often "hidden" and their activities covert or furtive, access to the means necessary to prevent HIV transmission is often severely limited, and both discourse about and interventions to improve this situation are rendered more difficult.

For all these reasons, responding to the threat of HIV/AIDS in prisons is more difficult than outside. At the same time, prisons offer important opportunities for the prevention of HIV transmission because a significant proportion of people who pass through them engage in high-risk activities, injection drug use in particular.[6]

Presumptions and Principles

The following are some of the presumptions and principles that have guided ECAP's work.

First of these are the "core values" expressed in the *Mission of the Correctional Service of Canada*.[7] These include the presumption that the goal of imprisonment is rehabilitation, not punishment, and the recognition that offenders, as members of society, retain their rights and privileges "except those necessarily removed or restricted by the fact of their incarceration."[8] A corollary is the principle that the same standards of health care and protection that apply to people outside prisons should also apply to offenders (community equivalence).

Second, ECAP was guided by the presumption that behaviour change is necessary to prevent or reduce transmission of infectious diseases in prisons. Importantly, this necessitates giving everyone in penitentiaries realistic opportunities to change their behaviour in such a way that exposure to infectious diseases will be avoided or reduced. Efforts to reduce the transmission of infections inside prisons, as outside, must be persistent and sustained, since it is unrealistic to believe that everyone will behave in such a way that the spread of infectious diseases, in particular HIV, will stop completely.

Third, prohibiting or suppressing behaviour that can transmit infectious diseases is often ineffective and may be counterproductive. Efforts to prevent the transmission of infectious diseases in correctional facilities should promote safer behaviour, enlist the cooperation of people in avoiding or reducing exposure, and emphasize respect for the rights and dignity of people.

Fourth, whatever measures are taken to prevent infections in prisons, they will protect both inmates and staff. Lowering the prevalence of infections in correctional facilities means that the risk of exposure to these infections will also be lowered. Efforts to prevent infection should not be viewed as favouring either inmates or staff, and efforts that protect inmates do not conflict with those that protect staff.

Fifth, ECAP was guided by a "health model" or harm-reduction model for dealing with HIV/AIDS and drug use in prisons. Several of the conclusions the Committee reached may appear to conflict with established penitentiary policy. For example, distributing condoms, making bleach available for cleaning injection equipment, educating prisoners about how to inject drugs safely, and providing explicit educational materials would appear to conflict with laws, policies or standards according to which sexual activity is an

institutional offence, drug possession (and use) a criminal offence, and the provision of graphic literature considered offensive to the prison community and the public. However, such measures may be necessary to protect inmates, staff and the public from the much greater harm that HIV infection represents, and may be seen as part of a "health model" or harm-reduction model for dealing with HIV/AIDS and drug use.[1]

The Solicitor General's decision in January 1992 to make condoms available in federal penitentiaries is an example of this "lesser harm" approach to the threat posed by HIV infection in federal correctional institutions. Implementing condom distribution in penitentiaries has not resulted in any documented negative or adverse impact; indeed, it appears to have had a beneficial impact. It has opened discussions about sexual activity and about preventing disease in penitentiaries. In addition, it has signaled how seriously CSC is taking the threat of HIV transmission, and its commitment to promote and protect the health of inmates and prevent infection among them.

Responding to HIV Infection and Drug Use in Prisons: Specific Issues

At its first meeting, ECAP identified 14 major issues it considered needed to be addressed by the Committee. ECAP concluded that responding to each of these issues would be necessary if HIV transmission and its adverse consequences in federal correctional facilities were to be prevented.

The issues are:

1. Seroprevalence Studies
2. Testing for HIV Infection
3. Offender Medical Information
4. Housing and Activities
5. Educational Programs for Inmates
   - 5.1 Education about HIV/AIDS
   - 5.2 Education about Drug Use
6. Preventive Measures for Inmates
   - 6.1.1 Consensual Sexual Activity
   - 6.1.2 Status of Consensual Sexual Activity
   - 6.2 Non-consensual Sexual Activity
   - 6.3 Preventing the Harms from Injection Drug Use
   - 6.4 Preventing the Harms from Tattooing
   - 6.5 Preventing the Harms from Piercing
7. Protective Measures for Staff
8. Health Care
9. Tuberculosis
10. Prison Health Services
11. Compassionate Release
12. Aftercare
13. Women Inmates
14. Aboriginal Inmates

ECAP has examined each of these issues, and the Committee's recommendations relating to each of them are presented in the *Final Report*. For each issue, the Report briefly reviews CSC policy and practice pertaining to that issue (Current Situation), what others have commented on regarding the issue (Debate), the Committee's assessment of it (ECAP's Assessment), and recommendations about what might be done in response to it (Recommendations).

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[1] In the context of drug use, such a model has been defined as follows (see Riley D. Drug Use in Prisons: A Harm Reduction Approach. Submission to ECAP, January 1993 at 5):

> Although harm-reduction approaches seek to reduce the use of drugs, harm-reduction has as its first priority a decrease in the negative consequences of drug use.... According to a harm-reduction approach a strategy which is aimed exclusively at decreasing the prevalence of drug use may only serve to increase the level of various drug-related harms. ... Harm reduction tries to reduce problems from drug use and recognizes that abstinence may be neither a realistic nor a desirable goal for some, especially in the short term. This is not to say that harm reduction and abstinence are mutually exclusive but only that it is not the only acceptable and important goal. Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic ones to be achieved in steps on the way to risk-free use or, if appropriate, abstinence. Harm reduction is consequently an approach which is characterized by pragmatism. ... Such strategies have been developed in a number of countries in response to the realization that the spread of AIDS is a greater danger to individual and public health than is drug misuse.

Responding to HIV Infection and Drug Use in Prisons: Broader Issues

Although ECAP has addressed the specific issues listed above, there are several issues the Committee could not address. These are the broader social issues that underlie many of the specific issues ECAP has examined. They include Canada's views on and responses to the use of drugs, intimate or private behaviour, vulnerability, aggression, violence and crime, and the status of women and Aboriginal populations. The Committee could not address these broader issues in greater detail because their magnitude and complexity would require more time and resources than were realistically available. Nonetheless, these issues are briefly discussed here. Although the Committee found that there is much that can be done immediately to prevent HIV transmission in prisons, sooner or later these broader issues will have to be addressed in the context of Canadian prisons; otherwise, efforts to promote and protect the health of staff and inmates and to prevent infections in Canadian prisons will be limited.

- **Drug Use**

Throughout history people have used drugs to "receive pleasure or to achieve new experiences."[9] It has even been said that drug use is a basic "human trait" and that the desire to alter consciousness is as deep as the need for food, shelter and love.[10]

Drug use among prisoners is a universal problem in Canada as elsewhere. Riley recently claimed that many of the inmates of federal and provincial correctional institutions use drugs as part of their lifestyle and that there are no strong deterrents to drug use in prison because "withholding privileges has little effect compared to the high positive reward value of drugs."[11] She further pointed out that inmates "may be involved in an active drug trade that defies all barriers and sets up conflicts involving debts and coercions," that inmates can "make a great deal of money selling drugs," and that the price of drugs in prisons can increase from 200-500% over street value."[12] The drug trade is a major source of violence in federal prisons. Between 1985 and 1986 there were 6 murders, 69 major assaults and 3 suicides linked to alcohol or other drug use.[13]

Riley concluded by saying:

> The impression is often given that prisons are a separate world. In fact, of course, the opposite is true: prisons experience the problems experienced outside as well as their own unique problems, and there is a constant flow of people between prisons and the general population.[14]

Among the many issues that ECAP considered, drug use is perhaps the most complex and problematic. CSC has diligently tried to prevent drug use in its institutions. Despite these efforts, drug use, including the injection of drugs, continues to occur. The Committee heard repeatedly that inmates would share their injection equipment, and would often do so without cleaning it between uses. As is the case outside prisons, efforts to prohibit drug use are costly and not always successful. Such efforts include interdiction of drugs and the penalization of possession (and use), education, and treatment programs. Since it is unrealistic to believe that all inmates will stop their drug-injecting behaviour, HIV is likely to spread relentlessly among injection drug users until they stop sharing their equipment or always clean it between uses. Other alternatives with which to respond to this problem appear unacceptable. Permitting drug use in penitentiaries in such a way that it can be done safely is unrealistic, given the legal prohibitions and public attitudes against drug use. On the other hand, allocating even greater resources to eradicating drug use is unlikely to be successful and would probably only drive drug users further underground and reinforce unsafe injecting practices.

Since efforts to suppress drug use are unlikely to eliminate the risk of HIV transmission and since drug-injecting behaviour is likely to persist, the only realistic option to successfully prevent infections is to encourage drug users to always

use clean injection equipment and to provide them with the means to do so. There is accumulating evidence that injection drug users can and do change their behaviour in the face of HIV infection.[15] They will clean their injection equipment or not share it if sufficient equipment is accessible. Importantly, making these materials accessible has not increased the prevalence of injection drug use. In order to reduce the harms from drug use in prisons and, in particular, to prevent or reduce transmission of HIV and other infectious diseases, inmates need to be able to always use clean injection equipment. This harm-reduction approach should in no way be interpreted as condoning drug use. Rather, it should be seen as discouraging unsafe injecting behaviour. Other interventions that may be implemented include making methadone programs available to offenders and giving offenders the option of detention in so-called drug-free areas.[2] However, these interventions may be considered to be band-aid solutions until the underlying issues are resolved. In the context of prisons, the two most prominent of these issues are preventing HIV infection among drug users outside prison, and reducing the number of drug users who are incarcerated.

Worldwide, the prevalence of HIV infection in prisons has been found to be closely related to the proportion of inmates who injected drugs prior to their imprisonment, and to the prevalence of HIV infection in their community.[16] This means that some inmates will enter prisons already infected; for those not infected when they enter prison, persistent injection drug use in prison without access to clean injection equipment means that HIV infection will be unavoidable. Some offenders will begin using drugs when they are incarcerated. And a significant number of inmates share injecting equipment for the first time when they are in prison.[17]

When people using drugs are sent to prison, responsibility for dealing with their drug use and the harms deriving from it, including HIV/AIDS, is shifted to the correctional system. As the number of drug users who are incarcerated increases, this will only augment the problem. As Harding has stated, "prisons are the single largest response to the drug problem in most European countries" and "more resources are used in moving drug users through the criminal justice system in Europe than any other form of management, medical or social."[18] Reducing the number of drug users who are incarcerated in federal penitentiaries is one possible way that HIV transmission in prisons may be lessened. Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available. As the World Health Organization has stated, "[g]overnments may ... wish to review their penal admission policies, particularly where drug abusers are concerned, in the light of the AIDS epidemic and its impact on prisons."[19]

- **Health Care and Confidentiality**

One of CSC's norms is that there should be community equivalence in the health care and support services available to inmates. In other words, these services should not differ in quality or accessibility from those available to people outside of prisons.[20] However, one of the major concerns repeatedly expressed by inmates is their lack of confidence in prison health services, in particular the confidentiality of personal medical information. They are often reluctant to use these services, and have expressed a desire for access to some services outside penitentiaries. These concerns have sometimes been difficult to evaluate and the provision of health care presents formidable logistical problems for CSC. The *Final Report* discusses these issues at some length. However, HIV infection presents additional

[2] Drug-free detention units have been available in a number of prisons in the Netherlands since 1983. Prisoners who apply to be housed in such units must refrain from using drugs and submit to regular urine tests. They have no contact with the rest of the prison population and participate in special programs.

problems for prison health services, in particular the emerging specialty nature of the expertise needed for diagnosis and treatment. Another issue is that of testing for HIV infection in penitentiaries. Testing raises exceedingly sensitive issues relating to the benefits, risks and harms from testing, disclosure of test results to others, and the possibility of abuse of this information. The fact that prisons are closed communities compounds these risks and harms. Again, the *Final Report* addresses these issues.

Underlying all these issues is the inmates' lack of confidence in prison health services. There are a number of reasons for this, and addressing many of them goes beyond ECAP's mandate. However, until they are dealt with many of the problems created by infectious diseases and drug use in penitentiaries will not be resolved easily or effectively. Nonetheless, the Committee has sought to formulate implementable interim measures.

One of the major concerns is that inmates often do not trust prison health-care personnel. Outside prisons, people are free to choose a professional who can meet their individual health needs. When they find such a person, trust between patient and professional is reinforced, impediments to care are lessened, compliance is increased, and disclosure of personal – often intimate or sensitive – information is facilitated. This is not feasible in prisons because of the restricted liberty of inmates and concerns about security. However, a novel approach that has been developed in some provincial correctional institutions in Quebec provides a potential solution to this problem through the provision of services by outside community clinics independent of prisons. The provision of such services has both merit and appeal. It would increase inmates' confidence in these services, increase their use of them – leading to earlier interventions relating to disease – encourage discussion, counselling and testing for infectious diseases, and serve to demarcate personal medical information from other personal information in the institution's possession. ECAP considers that CSC's Health Care Advisory Committee should further study this issue.

- **Staff Health and Safety**

Another very complex issue is that of promoting and protecting the health of staff, in particular staff potentially exposed to violent or aggressive inmates. It was apparent to ECAP that infectious diseases, and HIV infection in particular, are perceived to be a serious threat to staff health and safety. This has often led to claims that staff "need to know" the HIV status of infected offenders and to demands that staff be provided with more and better protective clothing. ECAP has examined these claims. However, although ECAP recognizes staff's concerns about the need for protective equipment, the Committee could not study the issue extensively. The Committee therefore encourages the steering committee established by the National Joint Occupational Safety and Health Committee with a mandate to study the issue of protective clothing and equipment to continue its efforts to provide CSC with proposals concerning improved protective equipment. At the same time, ECAP felt that improving staff understanding about HIV infection and AIDS is more important than knowledge about an individual's HIV status or the provision of protective equipment. There is extensive experience in managing HIV infection in health-care institutions, in particular preventing exposure to potentially infectious materials such as blood. Despite efforts by CSC to educate staff about the issue, this experience has not been effectively transferred to the prison setting, or has not had the educational and behavioural impact it merits.

Preventing workplace injuries has been an infection-control priority in health-care settings. In the prison setting, avoiding injuries will not always be possible. However, reducing the number of injuries from direct confrontation, and thus the risk of exposure to infectious diseases, should be a priority for CSC staff. Otherwise, efforts to protect staff from exposure will lead to excessive emphasis on protective clothing rather than on reducing exposure. Carried to its logical conclusion, an approach emphasizing the importance of protective clothing would find staff in "space suits," and infected inmates isolated. A preferable approach would be to put increased

emphasis on learning to deal with aggressive or violent behaviour so that accidents would be reduced. Consequently, there is a need for a reassessment of the management of aggressive or violent behaviour that can lead to risk-producing situations in prisons.

- **Women Inmates and Aboriginal Inmates**

Many of the issues relating to HIV/AIDS and drug use in prison are similar for all inmates, but sometimes preventing HIV infection among female inmates and Aboriginal inmates and caring for them presents different challenges than among male and non-Aboriginal inmates.

Women constituted only 2.1 percent of the on-register offender population in 1991.[21] However, the seroprevalence study undertaken in a provincial medium-security prison for women in Montreal[22] and the study of HIV prevalence in provincial adult correctional facilities in British Columbia,[23] as well as a series of studies undertaken in prison systems in other countries have shown higher rates of HIV infection among female inmates than among male inmates, in particular among female inmates who have a history of injection drug use. Women generally experience HIV infection and AIDS differently than men, both socially and physically. The problems they encounter in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. Many female inmates suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care.

ECAP has attempted to address some of these problems, but it could not address the broader social issues that give rise to or underlie many of them. ECAP concluded, among other things, that there is a need for greater sensitivity to the special concerns and needs of women in prison, for educational and prevention efforts that reflect this sensitivity and are specifically targeted at women inmates, and for increased efforts to empower women inmates so as to decrease their vulnerability to abuse in general and to HIV infection and drug use in particular. What ECAP was unable to do, and what so urgently needs to be done, is to address the vulnerability and the abuse many female offenders suffer outside prison.

Aboriginal inmates are another vulnerable population in federal penitentiaries. Compared with other Canadians, Aboriginal people are vastly overrepresented in the country's penitentiaries. In 1991-92, Aboriginal offenders accounted for 10.8 percent of the male and 19.8 percent of the female federal inmate population.[24] In some institutions the percentage is much higher. For example, in the Prairie Region, Aboriginal offenders accounted for 35.5 percent of the male and 55.3 percent of the female federal offender populations.[25] The problems causing this overrepresentation could not be addressed by ECAP. However, ECAP has studied some of the special concerns and needs of Aboriginal inmates in prisons. The Committee's recommendations regarding these issues are included in this *Final Report*. ECAP found that there was much that could be done to improve the health and welfare of Aboriginal people who are incarcerated.

The predominant culture in penitentiaries is not an Aboriginal one. As a result, Aboriginal inmates must reconcile living in what may be considered an "alien" culture. For them, many of the problems that have led to their imprisonment, to drug use and to exposure to HIV, or that result from imprisonment, from drug use and from HIV infection, cannot be addressed effectively or efficiently without an understanding of the "cultural meaning" of their behaviour.[26] It was clear to ECAP that CSC understands the problem and is trying to respond to it. However, HIV infection imposes new demands on CSC and the prison community to respond to the pandemic and therefore to respond to these underlying cultural issues. With regard to Aboriginal offenders, this requires even greater efforts to overcome cultural

barriers so that interventions to prevent HIV infection among Aboriginal offenders, care for those who are infected, and protect them from even greater vulnerability and abuse, are effective. Such interventions include providing for access to and use of traditional medicines, healers and healing ceremonies; culturally sensitive and specific communication and educational programs; and efforts to reinforce respect for social and religious values. This challenge is not unique to prisons, and to respond to this issue only in prisons would be a partial response. Many of the problems that arise for Aboriginal offenders in prisons have their roots outside prison and need to be addressed within a much broader context.

- **Federal/Provincial Split in Jurisdiction**

By virtue of Canada's constitution, jurisdiction for the criminal justice system is divided between federal, provincial and territorial governments.[27] Under the *Constitution Act, 1867*, the provincial legislatures have jurisdiction over "prisons" under s. 92(6), while the federal Parliament has jurisdiction over "penitentiaries" under s. 91(28). The Constitution does not supply definitions of prisons or penitentiaries.[28] The distinction among these different types of penal institutions is set out in section 731 of the *Criminal Code of Canada*, which prescribes that offenders sentenced to prison terms of two years or more must be sentenced to serve their terms in a federal penitentiary. CSC provides these services under the auspices of the federal Ministry of the Solicitor General. Offenders receiving sentences of less than two years are sentenced to provincial institutions – that is, prisons. After being convicted, however, federal prisoners are normally held in provincial institutions for a 15-day appeal period prior to being transferred.[29] Additionally, inmates may be transferred between jurisdictions under so-called exchange-of-service agreements that exist between the federal government and most provinces.[30] These agreements "are negotiated for such purposes as transferring inmates across jurisdictions, accommodating parole suspensions, and providing for the delivery of parole supervision, community assessments, health, psychiatric and educational services."[31] In some provinces, municipal governments also share responsibility for the delivery of custodial services. These services consist mainly of providing temporary lock-up and/or remand services.[32]

The provincial legislatures have jurisdiction over provincial prisons, but the federal government, under the *Prison and Reformatories Act*, is responsible for the basic legal framework governing offenders serving sentences for violating federal statutes.

The complexity of Canada's correctional system has often been criticized. The so-called "two-year rule" has been described as "both arbitrary and the source of duplications and overlap in federal and provincial responsibilities, inasmuch as both levels of government perform many of the same functions, albeit on different populations of offenders."[33] Over the years, many task forces and committees have reviewed the rule,[3] but to date no change has been made to it. The degree of centralization of the provision of adult correctional services within each province or territory, types of facilities, inmates housed, institutional and community programs offered, and the degree of supervision, vary across Canada. There is also a variety of responses to HIV/AIDS in prisons in Canada, the federal government and each of the provinces and territories having adopted their own policies with regard to HIV/AIDS in prisons. Although these policies resemble each other in many respects, there are often considerable differences in the way the problems arising from HIV/AIDS in the prison system are dealt with.

ECAP was not mandated, and therefore did not attempt, to review the "two-year rule." However, the split in jurisdiction between federal and provincial prison systems does have implications for dealing with HIV/AIDS and its consequences in federal correctional institutions. Offenders are

[3] The last major federal-provincial review of the matter was in 1976-78, in the form of the federal-provincial Steering Committee on the Split in Jurisdiction in Corrections.

often transferred between different types of institutions. A consistent response to HIV/AIDS would minimize the spread of HIV infection by ensuring that all inmates, whether in federal or provincial institutions, have access to education, services and support that are necessary to prevent the spread of HIV infection.

Some of the respondents to ECAP's *Working Paper* explicitly encouraged the Committee to provide an analysis of the extent to which conclusions in the *Working Paper* are relevant to provincial systems. For example, William Hart, Chairman of the Nova Scotia Advisory Commission on AIDS, stated:

> Although the document was intended to review AIDS-related issues in federal correctional institutions, the usefulness of the document could be expanded if it included a section about provincial correctional facilities. If the authors were to provide an analysis of the extent to which recommendations contained in the document are relevant to provincial systems, provincial organizations such as ours would be able to use the document as a more effective lobbying tool.[34]

ECAP could not analyze the extent to which each of its recommendations would also apply to provincial correctional institutions. However, the Committee was pleased with the response to the *Working Paper* of Quebec's correctional services directorate, which stated that the conclusions in the *Working Paper* [TRANSLATION] "are for us becoming guidelines to resolving the problems that we face." ECAP believes that most of the efforts that need to be undertaken to reduce or prevent HIV infection in federal correctional institutions also need to be undertaken at the provincial level and that many, if not all, of its recommendations could be implemented also in provincial prisons. ECAP certainly encourages provincial prison systems to consider this.

Another respondent to ECAP's *Working Paper* suggested that, in preparing the *Final Report*, ECAP should not only inform provincial jurisdictions of its recommendations, but also encourage CSC to confer with provincial jurisdictions "with the goal of establishing standards of service/performance with regard to the issues addressed or at least a model for them to emulate."[35] ECAP agrees with this statement and recognizes that there is a need for coordination and collaboration in responding to HIV/AIDS in prisons in Canada. This need has also been recognized by others. In particular, CSC has been urged to coordinate its efforts in the area of prevention of HIV/AIDS with provincial corrections branches.[36] In the summer of 1993 the Federal/Provincial Corrections Health Education Steering Committee of British Columbia submitted a funding proposal for an educational program on HIV/AIDS and infectious diseases. In October 1993 the program received funding, and will be carried out by health educators, contracted jointly to federal and provincial correctional services. This joint effort is an attempt to ensure "uniformity and consistency of information, consistently delivered throughout all correctional facilities."[37]

The Committee strongly supports such joint initiatives. It feels that, particularly in the area of education and prevention, coordination of federal and provincial efforts will be important to ensure consistency of information, and that the means necessary to prevent HIV infection will be available to all provincial and federal inmates. ECAP therefore encourages CSC and the provincial correctional systems to collaborate closely on the issues raised by HIV/AIDS and by drug use in prisons.

METHODS

MEETINGS

The Committee met eight times:

- 4 September 1992 (Ottawa);
- 31 October 1992 (Abbotsford);
- 4 December 1992 (Montreal);
- 4 February 1993 (Kingston);
- 26 February 1993 (Ottawa);
- 11 May 1993 (Ottawa);
- 5 October 1993 (Ottawa);
- 24 October 1993 (Vancouver).

In addition, the Committee met with:

- Ron Shore, Kingston AIDS Project (19 November 1992);
- Joan Anderson, Chair, Board of Directors, Canadian AIDS Society (22 January 1993);
- Representatives of the Union of Solicitor General Employees (11 February and 8 March 1993);
- Assistant Commissioners, Correctional Service Canada (23 February and 5 October 1993);
- John Edwards, Commissioner, Correctional Service Canada (26 February 1993);
- Susan Ohrt, Special Assistant to the Solicitor General of Canada (26 February and 5 October 1993).

PRISON VISITS

The Committee visited federal penitentiaries in British Columbia, Ontario and Quebec. This provided an opportunity to tour the institutions and hear the concerns of prison authorities, staff and inmates regarding HIV/AIDS and drug use in the prison environment. The Committee has considered this an important aspect of its work.

- British Columbia: Matsqui and Mission institutions (30 October 1992);
- Ontario: Prison for Women, Kingston Penitentiary and the Regional Treatment Centre (19-20 November 1992);
- Quebec: Regional Reception Centre, Ste. Anne des Plaines Institution; and the Federal Training Centre (3-4 December 1992);
- Consultation with Aboriginal people: Native Sisterhood of the Prison for Women and representatives of the Native Brotherhoods of several federal penitentiaries at the Prison for Women (3-4 February 1993).

REVIEW OF POLICIES AND LITERATURE

The McGill Centre for Medicine, Ethics and Law collected and reviewed national and international

policies, reports and documentation relating to HIV/AIDS and to drug use in prisons. Surveys of Canadian and international prison policies relating to HIV/AIDS have been included in *HIV/AIDS in Prisons: Background Materials* as Appendices 1-3.

Further, Canadian case law and precedents that have dealt expressly with HIV/AIDS in prisons, or could be applicable to situations raised by HIV/AIDS in prisons, have been analyzed to identify patterns of problems related to HIV/AIDS in Canadian prisons. A survey of Canadian case law and precedents has been included in *HIV/AIDS in Prisons: Background Materials* as Appendix 4.

SUBMISSIONS AND CORRESPONDENCE

Letters were sent to selected national and international bodies, groups and individuals, requesting information and asking them to make submissions to ECAP. Among those to whom letters were sent are:

- provincial and territorial ministries of health;
- provincial and territorial ministries responsible for the provision of young offenders and adult correctional services;
- federal, provincial and territorial human rights commissions;
- provincial and territorial drug abuse commissions;
- individuals and groups in Canada with an interest in the issue;
- selected correspondents from the international HIV/AIDS in Prisons Information Exchange Network managed by the University Institute of Legal Medicine, Geneva.

ECAP has received 91 submissions from agencies, groups and individuals with an interest in the issues raised by HIV/AIDS and drug use in prisons, and has addressed many of the issues discussed in these submissions in the *Working Paper* and in the *Final Report*. A list of the submissions has been included in *HIV/AIDS in Prisons: Background Materials* as Appendix 9.

QUESTIONNAIRES

A questionnaire on prisoners' opinions and concerns regarding education about HIV/AIDS and drug use, availability of condoms, clean needles and syringes or material to clean injection equipment, and testing and confidentiality, was sent to inmate committees in federal penitentiaries. Further, inmates were urged to contact ECAP with suggestions, recommendations or comments regarding HIV/AIDS and drug use in prisons.

A second questionnaire was sent to prison staff to obtain information regarding staff concerns about safety and the concerns of prison authorities with regard to the maintenance of safety and order in the prison environment.

Responses to these questionnaires have been analyzed, and the results have been included in *HIV/AIDS in Canada: Background Materials* as Appendices 5 and 6.

CONFERENCES

(1) A special session on "HIV/AIDS in Prisons," organized by ECAP's Project Coordinator, Dr. Ralf Jürgens was held in Vancouver at the 6th Annual British Columbia AIDS Conference, called *Living with HIV/AIDS*, on 2 November 1992. This session provided an opportunity to discuss the issues raised by HIV/AIDS in the provincial and federal prison systems, identify the concerns of prisoners and of prison staff and authorities, and solicit possible solutions to problems raised by HIV/AIDS. The speakers at the session and titles of their talks were:

- Michael Linhart, Inmate, Mission Institution, *An HIV Positive Prisoner's View*;
- Rodger Brock, Warden, Mission Institution, *A Warden's Perspective*;

- John Turvey, Downtown Eastside Youth Activities Society, *The Role of Community Groups*;
- Ray Sill, Allied Indian Metis Society, *Aboriginal Prison Populations and HIV/AIDS*;
- Barry Lynden, Programs Analyst, B.C. Ministry of the Solicitor General, and Ron Painter, Director, Surrey Pretrial Service Centre, *The Action of the B.C. Corrections Branch*;
- Robert Adlard, Director, Health Care Planning, Correctional Service Canada, *The Action of the Correctional Service of Canada*;
- Jim Elliot, Chief of Health Care, Mission Institution, *Health Care in Prisons*;
- Ralf Jürgens, ECAP Project Coordinator, *HIV/AIDS and Prisons: Analysis of Policies and Relevant Case Law*;
- Diane Riley, Senior Analyst, Canadian Centre on Substance Abuse, *Drug Use in Prisons*.

Texts of two of these presentations have been included in *HIV/AIDS in Prisons: Background Materials* as part of Appendix 8.

An indication of the success of this meeting was that the organizers of the British Columbia AIDS Conference asked ECAP's Project Coordinator to plan a session on HIV/AIDS in prisons for the 7th Annual British Columbia AIDS Conference, called *HIV in Canada Today*, held on 25 October 1993. The speakers at the session and titles of their talks were:

- Ralf Jürgens, ECAP Project Coordinator, and Donald Yeomans, ECAP Member, *HIV/AIDS and Prisons: New Developments in Canada and Abroad*;
- Diane Rothon, Director, Health Services, B.C. Corrections, *Results from the HIV Prevalence Study of Inmates in B.C. Prisons*;
- Liviana Calzavara, Assistant Professor, Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto, *Results from an Anonymous Unlinked HIV Seroprevalence Study of Inmates in Ontario*;
- Fred Hitchcock, Regional Coordinator, Disordered Offender Project, B.C. Ministry of Attorney General, Corrections Branch, *Guidelines for Improved Working Relationships between Hospital and Corrections Staff*;
- Jim Cairns, B.C. Ministry of Solicitor General, Corrections Branch, *B.C.'s Experience with Bleach in Prisons*;
- Michael Linhart, Inmate, Mission Institution, *An HIV Positive Prisoner's View: One Year Later* (video presentation);
- Andréa Riesch Toepell, Consultant, *Educating Prisoners about HIV/AIDS: Purpose, Politics and Practice*;
- Christiane Richard, Physician and ECAP Member, *Making Clean Needles Available to Prisoners?*
- Bert Kampuis, *Community Groups, HIV/AIDS and Prisons*.

Texts of some of these presentations are included in *HIV/AIDS in Prisons: Background Materials*, Appendix 8.

(2) At the 4th International Conference on the Reduction of Drug Related Harm, held in Rotterdam on 14-18 March 1993, Dr. Jürgens presented a paper based on the abstract "Reducing the Harms from Drug Use and from HIV/AIDS in Prisons" by Drs. Jürgens, Gilmore and Somerville.

(3) At the National Health Care Services Conference of the Correctional Service of Canada, called *Sharing the Goal*, which was held in Ottawa on 26-28 May 1993, Drs. Gilmore and Richard and Mr. Yeomans provided an update on the activities of the Expert Committee on AIDS and Prisons to health care staff of the Correctional Service of Canada.

(4) At the IXth International Conference on AIDS, which was held in Berlin on 7-11 June 1993, a poster on "HIV/AIDS in Prisons: Making Necessary Changes Possible" was exhibited by Drs. Jürgens, Gilmore and Richard.

(5) At a meeting of the senior management of the Correctional Service of Canada, which was held in Ottawa on 9 June 1993, Dr. Richard and Mr. Yeomans provided an update on ECAP's activities and presented the Committee's conclusions.

(6) At a public forum on "AIDS Behind Bars," held in Toronto on 6 October 1993, Dr. Jürgens made a presentation on ECAP's work and its conclusions.

(7) At the Canadian Congress on Criminal Justice, held in Quebec City on 12-15 October 1993, Dr. Gilmore and Mr. Yeomans made a presentation on "Stopping AIDS in Prison: In Pursuit of the Lesser Harm."

(8) At the 5th Annual Conference of the Canadian Bioethics Society, held in Montreal on 18-21 November 1993, Dr. Jürgens made a presentation on "Confidentiality of Medical Information Pertaining to Prisoners: A Legal and Ethical Analysis."

NEWSLETTER

Four issues of the Committee's newsletter, *ECAP NEWS*, were produced.

- Issue 1 (September 1992): summarizes ECAP's goal and mandate, presents the Committee members, and introduces the major issues that ECAP deals with.
- Issue 2 (November 1992): provides a summary of the presentations at the session on HIV/AIDS in Prisons at the 6th Annual British Columbia AIDS Conference, and addresses the issues raised by drug use in correctional facilities.
- Issue 3 (February 1993): addresses the challenges presented by the particular needs of female inmates and of Aboriginal inmates with regard to preventing HIV infection.
- Issue 4 (April 1993): addresses staff concerns about health and safety in the workplace.

WORKING PAPER

As part of its work, the Committee prepared *HIV/AIDS in Prisons: A Working Paper of the Expert Committee on AIDS and Prisons*. The *Working Paper* addressed many of the issues that HIV/AIDS and drug use raise in federal penitentiaries in Canada. It contained conclusions of ECAP's deliberations and suggestions for action.

Over 1000 copies of the *Working Paper* were distributed to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and drug use in prisons an opportunity to review the Committee's work and conclusions and to provide further input into the *Final Report*. Fifty individuals, groups and agencies have responded to the *Working Paper*, providing the Committee with valuable comments and criticism of its work. A list of those who have responded to the *Working Paper has been included in HIV/AIDS in Prisons: Background Materials* as Appendix 9.

ANALYSIS OF ISSUES AND POSSIBLE SOLUTIONS

1. SEROPREVALENCE STUDIES

CURRENT SITUATION

The number of prisoners with HIV infection or AIDS in federal penitentiaries is unknown, since there has been no widespread testing of prisoners for HIV infection. Only one study has been carried out in a federal correctional institution to determine the level of infection in its inmate population.[38] This study was undertaken at Joyceville Institution, a male medium security institution in Ontario in April of 1993. The study protocol was developed in conjunction with the penitentiary inmate committee. Participation was voluntary and testing was anonymous. In order to ensure confidentiality and to encourage maximum participation, individual demographic and risk-behaviour data were not collected. Fifty percent (297) of the total inmate population of 594 participated in this study, and three inmates were found to be HIV-positive (one percent). The interpretation and implication of these results are difficult to assess. First, as the researchers who undertook the study have emphasized, this point seroprevalence data may underestimate the true seroprevalence of HIV within the entire population of the institution. In particular, some inmates who consider themselves to be at high risk of having contracted HIV may have chosen not to participate in the study.[4] Further, extrapolation of the results of the study to other prisons, federal or provincial, "is not appropriate because of their differing inmate composition and transmission risks within each facility."[39] Indeed, even extrapolation to the same prison later may not be appropriate because of high inmate turnover.

Apart from the study at Joyceville Institution, only four studies have been carried out to determine levels of infection among inmates in Canadian prisons. The first two studies were carried out in Quebec provincial institutions over an extended period and, in order to determine behavioural risk

4] However, a study in Wisconsin compared the results of mandatory as opposed to voluntary testing of newly incarcerated inmates and found no significant difference in seroprevalence between the two groups (Ford PM, Connop PJ, Panaro L et al. Seroprevalence of HIV-1 in an Ontario Male Medium Security Penitentiary. Unpublished paper, 1993, with reference to Hoxie NJ, Vergeront JM, Frisby HR, et al. HIV seroprevalence and the acceptance of voluntary HIV testing among newly incarcerated male prison inmates in Wisconsin *Am J Pub Health* 1990;80:1129-1131). A similar study in Oregon produced the same result (Ford et al., with reference to Andrus JK, Fleming DW, Knox C et al. HIV testing in prisoners: Is mandatory testing mandatory? *Am J Pub Health* 1989;79:840-42).

factors, also collected demographic and risk-behaviour data.

The first study was undertaken in a medium-security prison for women in Montreal.[40,5] Of 321 participants, 23 (7.2 percent) were HIV-positive, 160 (49.8 percent) reported injection drug use, and 78 (24.4 percent) indicated prostitution as their main source of income just prior to incarceration. Ten of 60 (16.7 percent) injection drug users who indicated prostitution as their main source of income were HIV-infected compared with 11 of 100 injection drug users who did not engage in prostitution. Nonsterile injection drug-use practices and unprotected sexual activity with an injection drug user were found to be the strongest risk factors for HIV infection.[41]

The second study, of risk factors for HIV infection among incarcerated men, was undertaken in two provincial correctional institutions in Quebec from January 1990 to July 1992. Of 588 participants, 21 (3.6 percent) were HIV-positive. For 490 participants, combined information regarding previous injection drug use and HIV infection percentages are available. Of the 237 participants reporting a history of injection drug use, 18 (7.6 percent) were HIV-infected, while only one (0.4 percent) of the 253 participants with no history of injection drug use was HIV-infected.[42,6]

More recently, a study of HIV prevalence in provincial adult correctional facilities in British Columbia, was carried out by Dr. Rothon, Director of Health Services of the B.C. Corrections Branch.[7] The aims of the project included: (1) estimating the magnitude of the problem of HIV infection among inmates in provincial correctional facilities in British Columbia; (2) supporting the need for a comprehensive educational program on infectious diseases for inmates; (3) supporting the availability of condoms and bleach in B.C. correctional facilities; (4) anticipating future health-education and health-care resource requirements; (5) targeting certain critical groups or types of inmates based on demographic correlates such as gender, age or geographic location, with regard to health-care budgeting and prevention programs; (6) obtaining a baseline for future research on the impact of B.C. Corrections programs and initiatives related to HIV infection; and (7) comparing B.C. Corrections prevalence with the general population in Canada and other correctional jurisdictions in North America and abroad, where possible.[43]

The B.C. Corrections Branch conducted a pilot project using saliva-testing at the Surrey Pretrial Services Centre in April 1992. In October, November and December 1992, all adult inmates remanded to B.C. correctional facilities were asked to participate in the HIV prevalence study. A total of 2,719 inmates were interviewed and underwent the usual intake evaluation, which includes a medical history and physical examination. Personal and demographic data including data on age group, gender, intake centre, history of injection drug use and ethnic origin (Aboriginal or non-Aboriginal only) were also recorded. Testing was voluntary and specimens were unlinked. Testing took the form of saliva collection onto a piece of absorbent paper.

Of the 2,719 inmates interviewed, 237 (8.7 percent) refused testing and 28 tested positive (1.0 percent).[8] This compares with a seroprevalence rate of 0.1 percent in the general population of British Columbia. As indicated in the preliminary report on the study, one of the "most

[5] Preliminary data analysis was conducted on an initial group of 248 women. Of 130 women in this initial group who reported injection drug use, 108 (83.7 percent) had loaned or borrowed needles and 56 (51.9 percent) had done so with strangers. Thirteen (10.2 percent) reported having shared needles with an HIV-infected person. A striking 82 percent of all prostitutes in the initial group reported using injection drugs prior to incarceration.

An additional 474 women were interviewed between January 1990 and May 1992. Statistical analyses were underway at the time of writing. A report will be available by February 1994.

[6] A total of 972 inmates participated in the study. A final report will be available by February of 1994.

[7] A more detailed account of this study has been included in *HIV/AIDS in Prisons: Background Materials*, Appendix 8.

[8] In the study, inmates who refused to be tested were treated as though they were in fact negative. If any of the refusers had been tested and had been HIV positive, the prevalence would have been higher.

significant correlations" with HIV positivity was gender: the overall seroprevalence rate for men, both Aboriginal and non-Aboriginal, was 0.9 percent, while the overall rate for women was 3.1 percent. Five of the 109 non-Aboriginal women (4.6 percent), but none of the 54 Aboriginal women interviewed, tested positive.[9]

Injection drug use was also found to be highly correlated with HIV positivity, especially in women; 854 inmates (31.4 percent) reported injection drug use. Of these, 2.1 percent tested positive, 85.1 percent tested negative and 12.9 percent refused testing.[10] Among 1,865 inmates who denied ever having injected drugs, 0.5 percent tested positive, 87.3 percent tested negative and 6.8 percent refused testing. In this study, the relative risk of an injection drug user testing HIV-positive was thus 4.2 times that of a person who did not report injection drug use. Among women, the relative contribution of injection drug use to HIV seropositivity was even higher, with 100 percent of women testing positive reporting that they had injected drugs. For men, injection drug use was a risk factor in 57 percent of cases.

Inmates were asked whether they knew they were HIV positive; 19 participants who said they were positive turned out to be HIV-negative, and 17 participants who said they were negative or did not know turned out to be HIV-positive. There were only 11 people who said they were HIV positive and actually tested positive. In her analysis of the study, Rothon sees this as a "clear indication that there is a serious risk of being wrong when we label patients by what they believe or say to be true regarding their HIV status."[44]

As a result of her study, Rothon made several recommendations to the B.C. Corrections Branch, including: that educational programs about HIV/AIDS should be continued, with special attention given to the needs of women and those under 30; that the availability of condoms and bleach in B.C. correctional centres should continue to be supported; and that the seroprevalence study should be expanded to youth centres.

A fourth study, on HIV prevalence in Ontario jails and detention centres, used an anonymous unlinked method to determine rates of HIV-1 infection among adult and young male and female offenders being admitted to Ontario prisons. Over 12,000 specimens were collected from 42 jails and detention centres over a six-month period. Information on age, gender, and history of injection drug use was also obtained. Urine, routinely provided at time of admission, was screened. About 1.2 percent of adult female and 1 percent of adult male offenders tested positive.[11]

The extent to which the results of these studies are applicable to federal correctional institutions is not known. It has been claimed that there are differences in seroprevalence between federal and provincial inmate populations and, in particular, that it would be misleading to link the seroprevalence rates estimated from the Quebec studies with any expected rates at the federal level.[45] With regard to the study undertaken in a medium-security prison for women in Montreal, it has been said that it consisted of an "exclusively female inmate population in an area of Quebec, which ... is heavily overrepresented by prostitutes and drug addicts."[46] To this, Dr. Hankins, who undertook the Quebec studies, replied by saying

[9] The analysis of the study notes, however, that this data must be interpreted carefully, particularly since only 54 Aboriginal women were approached for testing, 7 of whom refused to be tested. If any of the seven refusers had been tested and found to be positive, the rate for Native women would be very different.

[10] This means that the portion of the study population at highest risk accepted testing less often. The actual seroprevalence rate may therefore be higher than that found in the study.

[11] Detailed results of this study are now available and have been included included in *HIV/AIDS in Prisons: Background Materials*, Appendix 8. In contrast to the studies undertaken at Joyceville Institution and in British Columbia, which were based on voluntary participation, the Ontario study screened all routinely collected specimens and therefore did not require informed consent. A description of the methods used for the study was presented at the IIIrd Annual Canadian Conference on HIV/AIDS Research in Montreal: see Calzavara L, Major C, Myers T et al. An Anonymous Unlinked HIV Prevalence Study of Inmates in Ontario. Paper presented at the Conference, Montreal, Canada, May 13-15, 1993. See also Calzavara L, Major C, Myers T et al. Balancing Science and Demands of Interest Groups: An Anonymous Unlinked Study of HIV-1 Among Prisoners. Poster presented at the IXth International Conference on AIDS, Berlin, Germany, June 7-11, 1993.

that "[i]t has not been established whether provincial or federal prisons are more likely to incarcerate individuals at higher risk for HIV infection" and that "[r]ecent studies in the U.S. indicate that seroprevalence rates do not differ significantly between jails and prisons based on same-state jail-prison comparisons."[47]

Regardless of whether there are significant differences in seroprevalence between federal and provincial inmates, the studies undertaken in provincial institutions suggest that the problem of HIV/AIDS in Canadian prisons, including federal penitentiaries and regardless of gender, may be more widespread than has previously been thought.[48] This has been confirmed, at least to some extent, by the study undertaken at Joyceville Institution.

During the month of December 1993, 102 of 13,084 federal inmates were reported to be infected with HIV. This represents a substantial increase from the 56 of 12,838 federal inmates who were known to be infected as of the month of January 1992. Reported cases of HIV infection or AIDS increased in every region of CSC:[49]

	January 1992		December 1993	
	Number of Incarcerated Inmates	Reported Cases of HIV/AIDS	Number of Incarcerated Inmates	Reported Cases of HIV/AIDS
Atlantic	1,137	3	1,283	4
Quebec	3,792	40	3,668	60
Ontario	3,648	6	3,618	21
Prairie	2,659	5	2,800	8
Pacific	1,602	2	1,715	9
Totals	12,838	56	13,084	102

In the Quebec Region, nearly one in every 60 inmates (1.6 percent) was known to be infected with HIV as of December 1993. For the other regions, reported cases of HIV infection or AIDS per thousand incarcerated inmates were as follows:[50]

	January 1992	December 1993
Atlantic	2.63	3.12
Quebec	10.54	16.36
Ontario	1.64	5.80
Prairie	1.88	2.86
Pacific	1.24	5.25

These data suggest an overall infection rate in Canadian federal institutions of one in 128 inmates (0.78 percent). However, the study undertaken at Joyceville Institution, although it provides data on prevalence of HIV infection in only one federal institution, nevertheless suggests that the actual prevalence is higher. It has been claimed that it is more likely that the number of individuals with HIV infection in federal penitentiaries is closer to one in 20 than to one in 128.[51] While this would be consistent with the findings of the Parliamentary Ad Hoc Committee on AIDS which, in a report issued in 1990, suggested that "the actual number [of inmates with HIV infection or AIDS] must be so vastly different [from the official statistics] as to make these statistics a mockery,"[52] such a claim is unproven and seems unrealistic in light of the results of the above-mentioned studies.

Internationally, particularly high rates have been reported from countries in southern Europe; for example, 26 percent in Spain and 17 percent in Italy.[53] High figures have also been reported from France (13 percent; testing of 500 consecutive entries), Switzerland (11 percent; cross-sectional study in five prisons in the Canton of Berne) and the Netherlands (11 percent; screening of a sample of prisoners in Amsterdam).[54] In the United States, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. Many systems continue to have rates under one percent, while in a few, such as New York City or New York State, rates approach or exceed 20 percent.[55] For example, in New York State an estimated 17 to 20 percent, or approximately 9,000 of the state's 54,000 inmates, are HIV-positive.[56] In contrast, some European countries, including Belgium, Finland, Iceland and some Länder in Germany, report low levels of HIV prevalence.[57] Low rates of HIV prevalence, ranging from zero to 2.9 percent, have also been reported from Australia.[58] In general, caution must be exercised in comparing and interpreting the data from different countries because of the different methodologies used (e.g., mandatory testing of the entire prison population, screening of only those inmates who have engaged in so-called high-risk activities, voluntary testing). However,

these studies have consistently shown higher rates of HIV infection than in non-incarcerated populations.[59] Further, they have shown that the prevalence of HIV in the prison population is, in general, closely related to the proportion of those injecting drugs prior to imprisonment and to the rate of HIV infection among injection drug users in that community.[60] For example, a study in northern Italy that compared prisoners who were injection drug users with prisoners who had no known risk factors for HIV infection found that 36.3 percent of the injection drug users were HIV-positive, compared to 7.9 percent of the others.[61] A study undertaken in one prison in France found that 61 percent of prisoners who were injection drug users were HIV-positive.[62] Similarly, a study of HIV risk behaviour and HIV prevalence among ex-prisoners in England revealed an overall HIV prevalence rate of 5 percent, but among female injection drug users HIV prevalence was 15.5 percent and among male injection drug users 7.7 percent.[63] In the United States, the jurisdictions with the highest HIV prevalence in prisons are areas where HIV infection in the general community is "pervasive among IV drug users, who are dramatically over-represented in correctional institutions."[64] Commenting on this situation, the U.S. National Commission on AIDS stated that "by choosing mass imprisonment as the federal and state governments" response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection."[65]

In Canada, needle exchanges[12] have been established in major cities when rates of infection among injection drug users were still relatively low. They appear to have been successful in reducing the spread of HIV infection among this population and have provided it with education and facilitated access to a number of support services. Because injection drug users constitute by far the largest group of infected inmates, the relatively lower rates of HIV prevalence among injection drug users in Canada, compared with some European countries and some jurisdictions in the United States, suggests that the prevalence of HIV infection among inmates will also be lower. It further suggests that the establishment of needle distribution schemes outside prisons has been one of the major contributions to preventing the spread of HIV infection in prisons. Funded by Health Canada, evaluation of Canadian needle exchange programs is underway and results are scheduled for release late in 1993 (see also infra, page 69).

THE DEBATE

The necessity of undertaking studies on the prevalence of HIV infection in prisons has been the subject of extensive debate in Canada. In 1990, the Parliamentary Ad Hoc Committee on AIDS recommended "that the Department of National Health and Welfare, in cooperation with the Correctional Service of Canada, immediately set up a pilot study, using unlinked seroprevalence survey techniques, and with appropriate ethical safeguards, to assess the level of HIV infection in federal prisons."[66] At the time, the Commissioner of the Correctional Service acknowledged and lamented the lack of information on which to base an extensive HIV/AIDS prison policy, saying that he "did not have any hard information on the extent of HIV infection in the prisons."[67] However, he also suggested that it would not be possible to gather such information and that any attempt to do so would raise legal and ethical questions. To this the Ad Hoc Committee responded that "unlinked testing using left-over samples, which would bear no information identifying any particular inmate, would give us some reliable knowledge about the prevalence of HIV infection in the penal system" and that "[t]he same sort of testing using blood from incoming inmates, and from those being released, would give us a picture of how much infection was being incurred inside the prisons."[68] A study conducted in 1990 to assess the feasibility of scientifically estimating HIV prevalence and related risk behaviour among inmates found that this was not only technically but ethically feasible.[69]

[12] The term "needle exchange" is used here and in other sections of the report, although the Committee recognizes that it is under-inclusive and does not properly characterize the variety of outreach services that most "needle exchanges" offer their clients.

CSC has expressed the concern that conducting seroprevalence studies "might further stigmatize an already stigmatized population and, as well, raise contentious ethical considerations."[70]

The Federal/Provincial/Territorial Advisory Committee on AIDS recommended that "[h]ealth departments and the Solicitor General consider cost-shared commissioned research, within the context of available resources, specifically in the areas of a) surveys of knowledge, attitudes and behaviour; and b) HIV-prevalence surveys."[71]

Dr. Hankins, in her submission to ECAP, also supports undertaking seroprevalence studies. She argues that "[u]ntil studies are done to determine the true prevalence of HIV-1 infection among individuals incarcerated in federal institutions in Canada, claims that there are differences in seroprevalence between federal and provincial inmate populations cannot be validated."[72] She further argues that, if seroprevalence studies are not undertaken, "no clear picture of the extent and seriousness of the HIV epidemic in federal prisons can be obtained" and that "[i]n the absence of this information, policy development, resource allocation, and the evaluation of effective interventions, both prison and community-based, are severely impeded." However, Hankins emphasized that, "if a choice is to be made for financial reasons between establishing the rates of infection and policy changes which would allow for the provision of the tools of prevention to inmates, then the research should be waived in favour of preventive measures."[73]

Others have opposed undertaking seroprevalence studies. For example, in its brief to the Ontario Ministers of Correctional Services and of Health, the Prisoners with AIDS/HIV Support Action Network (PASAN) stated that "[w]e do not need HIV seroprevalence studies to know that HIV/AIDS is threatening prisoners' lives,"[74] and pointed out that "[t]he HIV/AIDS epidemic is known to be raging in prisons elsewhere"[75] and that therefore Canadian authorities should be aware that there is at least a possibility of an HIV/AIDS epidemic among Canadian prisoners. PASAN concluded that although "[t]here are some legitimate reasons for HIV testing ... in these times of economic restraint, HIV sero-prevalence studies may not be the wisest use of severely limited funds."[76] It added that "[t]horough HIV testing of inmates would be a very time-consuming and expensive procedure, using money that would be better spent improving the care of and services to prisoners with HIV/AIDS."[77] PASAN also expressed its concern that, given the problems with current testing programs in prisons, most HIV-seroprevalence studies would be unethical because the established ethical guidelines for such studies[78] require that universal access to confidential HIV-antibody testing be in place before a seroprevalence study is undertaken.[79]

The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* contain the following provision with regard to "evaluation and research" in prisons:

> 58. Studies concerning HIV/AIDS in prison populations are recommended in order to establish an adequate information base for planning policies and interventions in this field. Such studies could investigate for example the prevalence of HIV infection or the frequency of risk behaviours for HIV transmission.[80]

The issue of whether seroprevalence studies should be undertaken was also addressed in some responses to the *Working Paper*. Many respondents agreed with ECAP's conclusion. In particular, they agreed that studies should only be undertaken if they adhere to established ethical guidelines and if they are preceded by extensive consultation with prisoners and community representatives. Some opposed undertaking any seroprevalence studies. For example, one respondent stated that seroprevalence studies "are unnecessary and thus can never be cost effective" and that resources "are better allocated in the provision of anonymous HIV antibody testing accompanied by proper pre-and post-test counselling." The respondent concluded:

> As a means to slow transmission of HIV infection in Canadian prisons, anonymous HIV

antibody testing would allow inmates to become informed of their serostatus while at the same time receiving individual counselling about HIV transmission, thus sensitizing inmates to the threat of HIV and the necessity of reducing risk behaviours.

Seroprevalence studies, conversely, do not empower inmates to take control of their health or protect themselves and others from transmission of HIV. While in theory seroprevalence studies help in policy formation and resource allocation, the relationship between a high rate of seroprevalence and a strong commitment from those who make policy and allocate resources is unlikely to be direct. Too many variables are involved – mostly involved with the nature of party politics, elections and the current reliance in political circles on public opinion.[81]

Other respondents supported undertaking seroprevalence studies in federal correctional institutions. Dr. Calzavara found ECAP's conclusion that seroprevalence studies be put on hold "somewhat surprising." Although she agreed that the implementation of programs should not await the results of seroprevalence studies, she pointed out that seroprevalence studies "are a basic tool for monitoring HIV prevalence in all populations," that they serve to "identify subgroups with higher prevalence rates and to monitor changes in HIV prevalence rates over time," and that they are useful in "targeting prevention programs and evaluating their impact."[82] A recurrent theme in the responses that favour undertaking seroprevalence studies is the claim that they are needed to obtain a clear picture of the extent of the problem in federal correctional institutions.[13] This is consistent with the conclusion of Dr. Ford, who undertook the seroprevalence study at Joyceville Institution, that "[f]urther studies should be done across Canada at both the provincial and federal level to determine the extent of the problem."[83]

Dr. Rothon agreed with ECAP that additional HIV seroprevalence studies of inmates may not be justified on the basis of cost or necessity, saying that "at this point, there appears to be more than enough evidence to support that HIV is a serious problem in prisons." However, from her personal experience she added:

> [T]hough prior to the study, correctional and health care administrators generally accepted that HIV was a problem in prisons, only after the presentation of hard data, specifically applicable to our centres, was the problem brought into sharp focus. The impact of this study and its alarming prevalence rates did much to accelerate the planning and funding of educational resources, testing and counselling, increase awareness among staff and inmates, and reaffirm the need for condoms and bleach, already available in all B.C. Corrections facilities.[84]

ECAP'S ASSESSMENT

ECAP acknowledges the validity of many of the concerns raised in the responses to the *Working Paper* with regard to the potential utility of HIV-seroprevalence studies of inmates in federal correctional institutions. However, ECAP is concerned that seroprevalence studies may be expensive, may divert resources from or delay efforts to prevent the transmission of HIV and other infectious agents in correctional institutions,

[13] See, e.g., the responses to ECAP's *Working Paper* by Rodger Brock, Warden, Matsqui Institution, dated 27 August 1993, by Michael Linhart for the "Prisoners of HIV Group", Mission Institution, dated 7 September 1993, and by Kenneth Moritsugu, Assistant Surgeon General, Medical Director, U.S. Department of Justice, Federal Bureau of Prisons, undated. Dr. Moritsugu pointed out that in the United States, the Federal Bureau of Prisons has adopted a yearly stratified random sample for HIV testing. This sample constitutes approximately 10 percent of the total inmate population and is stratified according to several variables, e.g., race, ethnicity, gender, age, and level of offence, to provide a representative picture. This seroprevalence study is conducted during one month each year. Follow-up studies of a cohort of new commitments who were initially HIV-negative provide information on seroconversion. The statistics obtained through this method have been found "to be both reliable and valid, but of greater importance, they serve as an excellent basis for projection models for forecasting budgets and allocation of human resources." Such testing, however, would appear to be inconsistent with the 1993 World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons*, according to which "[u]nlinked anonymous testing for epidemiological surveillance should only be considered if such a method is used in the general population of the country concerned."

and considers them unnecessary for the implementation of these efforts.

ECAP considers that the most important response to the problem of HIV infection and AIDS in Canadian penitentiaries is to increase efforts to protect inmates and staff, promote their health, and prevent transmission of HIV and other infectious agents within these institutions. These efforts should include, among other things, increased and more effective education about HIV/AIDS and about drug use for both inmates and staff, better inmate access to condoms and to bleach, and increased efforts to provide staff with the ability to protect themselves from HIV transmission. These initiatives are discussed in detail below and, without exception, need to be undertaken regardless of HIV seroprevalence in correctional facilities. At the same time, ECAP acknowledges that resource allocation and evaluation of the effectiveness of interventions may be rendered more difficult in the absence of seroprevalence studies. However, the benefits of repeated testing programs that would facilitate decision-making on resource allocation and allow better evaluation of the interventions that are undertaken would not seem to justify their relatively high costs. Further, ECAP is concerned about the limitations of such studies. They provide point seroprevalence data (i.e., a "snapshot" of the situation) and their usefulness may be limited because of limited inmate participation in such studies, as has been the case in the Joyceville study, and because of confounding variables such as inmate turnover and differences among institutions. Keeping these limitations in mind, the results of the seroprevalence studies undertaken at Joyceville Institution and in provincial prison systems should be carefully evaluated to establish whether additional studies need to be undertaken. If additional studies are undertaken, they should be cost-effective, carried out under strict adherence to established ethical guidelines,[85] and be preceded by extensive consultation with inmates, community groups and independent experts.

RECOMMENDATIONS

1. **ECAP recommends that the results of the seroprevalence studies undertaken at Joyceville Institution and in provincial prison systems be evaluated to establish whether additional studies need to be undertaken. Any additional studies should only be undertaken if they are cost-effective, strictly adhere to established ethical guidelines, and are preceded by extensive consultation with inmates, community groups and independent experts.**

2. TESTING FOR HIV INFECTION

CURRENT SITUATION

Paragraphs 9 through 13 of Commissioner's Directive 821, Management of Inmates with Human Immunodeficiency Virus (HIV) Infections, read as follows:

9. Inmates, upon entrance into the correctional system or during incarceration, shall not be routinely screened for presence of antibodies to HIV.

10. HIV antibody testing shall be governed by the criteria for valid consent, as outlined in Commissioner's Directive No. 803, entitled Consent to Medical, Dental or Psychiatric Treatment.

11. Inmates wishing to be tested may make their request to the institutional physician. The institutional physician shall determine if testing is indicated, based on the need to confirm physical examination or laboratory studies suggestive of HIV infection. Requests for testing from inmates with a history of high risk activities associated with HIV infection shall be carried out at the discretion of the institutional physician.

12. All testing shall be preceded by a period of counselling by health care staff

regarding the possible implications of the test and test results.

13. Following testing, HIV seropositive inmates shall receive counselling from medical staff and shall have access to the full range of available institutional and community counselling services.

In accordance with this policy, testing for HIV infection in Canadian penitentiaries is undertaken only voluntarily – that is, with the informed consent of the inmate. Initially, testing was carried out at the discretion of the institutional physician. As a result, inmates had more limited access to testing than people outside prisons. This has since been addressed, at least in part, by making testing available at the inmate's request. This new practice is reflected in paragraphs 9 through 12 of a revised version of Commissioner's Directive 821 (pending approval), according to which inmates shall be offered testing for HIV antibodies. These paragraphs read as follows:

9. Inmates shall be offered testing for the presence of antibodies to HIV, but shall not be routinely screened.

10. HIV antibody testing shall be governed by the criteria for valid consent, as outlined in Commissioner's Directive No. 803, entitled Consent to Medical, Dental or Psychiatric Treatment.

11. All testing shall be preceded by a period of counselling by health care staff regarding the possible implications of the test and test results.

12. Following testing, HIV seropositive and seronegative inmates shall receive counselling from health care staff and shall have access to the full range of available institutional and community counselling services.

Testing is nominal and is carried out by prison health-care staff. Non-nominal and anonymous testing are not offered.[14]

In an effort to ensure that pre- and post-test counselling are carried out appropriately by health-care staff, CSC is currently assessing existing counselling guidelines, including those of the Canadian Medical Association,[86] with a view to adapting them to the correctional environment.

THE DEBATE

There is nearly unanimous support for CSC's policy and practice of undertaking only voluntary testing for HIV infection. This policy is consistent with the general principle governing HIV-antibody testing in Canada, according to which "HIV antibody testing should only be done when voluntary, that is with informed consent ..."[87,15] It is also consistent with provincial prison policies and practice and with the World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons*, which state:

10. Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited.

11. Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre-and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support

[14] Nominal testing is testing in which "the identity of the person being tested is known to the physician requesting the test and the laboratory performing it." Non-nominal testing is "testing in which results can be linked to the person being tested by a code (which does not include personal identification of the person being tested), known by the person being tested. The physician also knows the identity of the person being tested." Anonymous testing is "testing in which results can be linked to the patient by a code known only by the patient; the physician, etc. cannot know the identity of the person being tested." See Human Immunodeficiency Virus Antibody Testing in Canada. Recommendations of the National Advisory Committee on AIDS. *Canada Diseases Weekly Report* 1989:15-8:37-47 at 43.

[15] However, this principle also requires that testing only be done when confidentiality of results or anonymity of testing can be guaranteed. The full text of the principle is as follows:

> HIV antibody testing should only be done when voluntary, that is with informed consent, and when counselling and education before and following testing are available and offered, and when confidentiality of results or anonymity of testing can be guaranteed.

> should be available when prisoners are notified of test results and in the period following.[88]

In Canada, involuntary testing of inmates for HIV infection is deemed "unwarranted."[89] It is agreed that it would not be consistent with the provisions of the *Canadian Charter of Rights and Freedoms*. In this regard, the prison policy of Newfoundland and Labrador explicitly states:

> No person may be forced to submit to an HIV Antibody test. Such a test may only be administered by a medical professional if the patient provides informed consent. Any attempt to coerce an inmate to submit to the test in the absence of consent may not only be a violation of fundamental human rights under the *Charter of Rights* (the right to "life, liberty and security of the person" and the right to be "secure against unreasonable search or seizure") but may also be regarded as an offence under the *Criminal Code*.[90]

It was in the prison setting that the *Charter* was first used to declare invalid a pilot project that involved mandatory drug testing. In *Re Dion and the Queen*[91] it was found that random demands for urine samples to detect drug use violated the inmate's rights to life, liberty and security under section 7 of the *Charter*. Because there was no requirement that there be reasonable and probable grounds for demanding a sample, the power was held to be arbitrary and thus contrary to the principles of fundamental justice under section 1 of the *Charter*.[92] Similarly, in the case of *Jackson* v. *Joyceville Penitentiary*,[93] mandatory urine testing for drugs and alcohol in federal prisons was struck down by the Federal Court as a violation of sections 7 and 8 of the *Charter*.[16] The principles underlying these decisions would also be relevant to an HIV-antibody testing program.[94]

Recently, however, a recommendation was made by the Progressive Conservative Caucus Committee on Family Issues to "[a]mend the *Corrections and Conditional Release Act* to require all federal penitentiary inmates with a record of sexual, violent, or drug offences to consent to HIV-antibody testing, and to disclosure of the test results under certain conditions, in order to qualify for any form of release prior to the end of their sentences."[95] According to the Caucus Committee's report, which was released on 9 June 1993, the proposed legislative initiatives "are designed to help protect the public from being assaulted by dangerous HIV-infected federal inmates, and to ensure that the necessary information is readily available to victims in the event that such assaults occur." Inmates whose past record includes certain specified offences, who wish to be eligible for any form of conditional release, statutory release, or escorted temporary absences or work release programs, would be "required to consent" to HIV-antibody testing. The report further states:

> They would thus undergo voluntary testing,[17] or they would be detained until the expiry of their sentences. The inmate would further be required to consent to the disclosure of the test results, at the discretion of the institutional head, to a qualified medical practitioner on a confidential basis. The consent would cover disclosure for valid medical purposes involving

[16] According to ss. 54-56 of the recent *Corrections and Conditional Release Act*, CSC may carry out urinalysis when there are reasonable grounds to believe an offender has consumed drugs or alcohol. It is required for participation in a substance-abuse program or activity involving community contact and when an offender is on conditional release on condition that he or she abstain from alcohol or other drugs. Further, urinalysis may be carried out when it is part of a random check process in which every offender has an equal chance of being selected. The constitutional validity of this provision remains to be established.

[17] The use of the term "voluntary testing" in this context is inappropriate. Any testing that is a prerequisite for an inmate to be eligible for conditional release, statutory release, or escorted absences or work release programs, is, in fact, mandatory testing or even occult compulsory testing. To avoid confusion between voluntary, mandatory and compulsory testing, the following definitions are reproduced here. Testing is voluntary where it "is done only with the informed consent of the person to be tested ... and the testing does not fall within the definitions of mandatory or compulsory testing." Testing is mandatory where it is either a necessary prerequisite for a person to obtain a specified status, benefit, service or access to a given situation, or is a necessary consequence of being provided with one or more of these." Testing is compulsory where it "is required by law, or policy, and the person has no choice to refuse testing and cannot legally avoid it." See Human Immunodeficiency Virus Testing in Canada. Recommendations of the National Advisory Committee on AIDS. *Canada Diseases Weekly Report 1989; 15-8:37-47.*

> the physical or emotional health of any person who may be exposed to HIV because of the actions of the inmate while on release.[96]

Inmates who suspect that they may be HIV positive sometimes refuse to undergo nominal testing by prison health care staff because they fear being isolated and ostracized.[97] In order to encourage prisoners to be tested in prison and to ensure the confidentiality of test results, it has been widely recommended that alternatives to nominal testing carried out by prison health care staff be made available to inmates.

Some have argued that testing should be carried out by outside health services such as community clinics.[98] For example, the Prisoners with AIDS/HIV Support Action Network (PASAN) stated that inmates would be "more likely to trust a counsellor from a community-based agency, with whom they would not have to worry about a breach of confidentiality" and that "[a] 'safe' testing environment would likely lead to more inmates choosing to be tested and would therefore allow inmates to avail themselves of information, counselling, and treatment to delay the onset of HIV-related illnesses."[99] In addition, PASAN argued that permitting "outside" workers to offer counselling and testing in prisons would increase prison security because "[s]taff would feel protected by an informed population who begin to change their behaviour voluntarily."[100] Similarly, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all residents/inmates have access to "counselling and testing for HIV infection on resident/inmate request, with confidentiality of results and ongoing psychosocial support from appropriately trained persons acceptable to the resident/inmate."[101]

It has further been recommended that offenders should have access to anonymous testing.[102]

> [S]ome individuals at risk of HIV infection ... are concerned that their names will be reported to the public health system, and they fear discrimination and loss of privacy. Anonymous testing is intended to remove these barriers and encourage people at risk of HIV infection to come forward for testing and receive the medical and social services they require.[103]

Anonymous testing is available to people outside prisons in most provinces. It is also available to prisoners in one provincial prison in Quebec. The perceived advantages of, and the experiences in prisons with, alternatives to nominal testing carried out by health-care staff have been summarized as follows:

> Providing voluntary testing and counselling services can be cost effective and can simplify resource planning. Since the goal of testing is not to identify infected inmates for the purposes of segregation but rather to inform both non-infected and infected inmates of their results in order to assist them in adopting safer behaviours, the best programme will be the one which provides maximum encouragement to come forward for testing. In the Quebec experience, this has been a non-nominal testing service based on the principle that the control of information regarding serological status and the decision to initiate medical and psychological follow-up resides with the inmate himself or herself. The acceptability of this approach was evident from the continual demand for HIV antibody testing and counselling services from inmates as well as from correctional staff both during the study and after termination.[104]

In the prison setting, providing anonymous testing would imply that testing is undertaken by external agencies, because inmates are known to prison health care staff and any testing undertaken by them would not be truly anonymous. In contrast, non-nominal testing could be provided also by prison health care staff.[18]

[18] "Correctional health care staff would know who was being tested whether this was non-nominal or nominal but with a non-nominal approach only the inmate could make the link by presenting his or her code to get access to his or her own results. This means that the decision to receive the results resides with the inmate since health service staff cannot make that link." See the response to ECAP's *Working Paper* by Dr. C. Hankins, dated 30 August 1993.

ANALYSIS OF ISSUES AND POSSIBLE SOLUTIONS

ECAP's conclusions in the *Working Paper* with regard to testing for HIV infection have received wide, and sometimes unanimous, support. All respondents agreed that testing should always be voluntary – with the express consent of the inmate – and that it should be accompanied by counselling and education before and following testing. In a few responses, concern was voiced that appropriate counselling was sometimes not undertaken due to time constraints or lack of skill of health care staff. Most respondents also supported providing inmates with alternatives to nominal testing undertaken by prison health care staff, and 16 of 20 inmate committees, and 11 of 12 individual prisoners who responded to this question on ECAP's questionnaire, indicated that inmates should have access to testing by someone not connected with the prison system.[19] However, among respondents to the *Working Paper* there was some disagreement as to whether testing by personnel independent of CSC should be made available in all institutions. CSC staff at one institution felt that community clinics could be involved in minimum-security institutions as well as with day parolees, but not at medium- or high-security institutions.[105] A group of inmates questioned whether CSC would be ready to accept a system which would, in their view, reduce the need for testing services offered by the prison health care system.[106]

Most respondents and a vast majority of inmate committees and inmates responding to ECAP's questionnaire also agreed that anonymous testing should be made available to inmates. For example, the Office of the Privacy Commissioner of Canada stated:

> We support your conclusion that all inmates should have access to anonymous testing.[107]

Fifteen of 20 inmate committees, and 11 of 12 individual inmates responded that anonymous testing should be made available to inmates.

Similarly, in the knowledge, attitude and behaviour study undertaken by Dr. Toepell in two provincial institutions in Ontario, 86 percent of the interviewed inmates responded that anonymous testing should be available to anyone who requests it.[108]

Reflecting one of the Committee's concerns, one respondent emphasized that "if testing is being done or arranged through the Prison Health Care System the possibility of anonymous testing is non-existent."[109]

ECAP'S ASSESSMENT

ECAP commends CSC for its policy and practice of undertaking testing for HIV infection only when it is voluntary. In addition, ECAP strongly opposes any proposals for mandatory or compulsory testing of inmates or certain groups of inmates in federal correctional institutions as a precondition for parole or other forms of release. The Committee is concerned that benefits from such testing are very limited and questionable, while harms include breach of a person's right to inviolability, self-determination, autonomy, privacy and confidentiality, and the risk of discriminatory and other harmful treatment.[20]

ECAP further commends CSC for its current effort to assess pre- and post-test counselling guidelines in an effort to provide all inmates who choose to be tested with adequate pre- and post-test counselling.

However, ECAP was concerned that, while people outside prisons have universal access to testing, inmates have access only to nominal testing undertaken by prison health care staff, and frequently do not seek to be tested while in prison. There are at least three reasons for their reluctance to be tested:

[19] For more details, see *HIV/AIDS and Prisons: Background Materials*. Appendix 6: Results of the Inmate Questionnaire.

[20] This issue is addressed in more detail in the paper on "Disclosure of Offender Medical Information: A Legal and Ethical Analysis." See *HIV/AIDS and Prisons: Background Materials*, Appendix 7.

Limited access to testing

ECAP found that HIV testing on entry into the prison system is sometimes discussed only with inmates who acknowledge having engaged in so-called high-risk activities. As a result, some inmates may not be aware that HIV testing is available to them at their request on entry and while they are incarcerated. This situation could easily be corrected by discussing testing with all inmates on entry and informing them that testing is available, at their request, during incarceration.

Confidentiality of test results

Many prisoners have expressed reluctance to be tested for HIV antibodies because of concern that test results will not remain confidential. This is consistent with the findings of the Parliamentary Ad Hoc Committee on AIDS, which stated that the "most likely reason for the low number of inmates identified as HIV-positive in the federal prison system is the complete lack of confidence that most inmates appear to have in the confidentiality of prison health services" and that "many [inmates] have undoubtedly waited until they were released to be tested."[110] It was also confirmed by the results of the questionnaire that ECAP sent to inmate committees in federal institutions. Fifteen of 20 inmate committees and 12 of the 13 individual inmates who responded to this question on ECAP's questionnaire, expressed concern that inmates would not seek testing because of fear their test results would not remain confidential.[21]

In view of the sensitive nature of personal information relating to HIV infection and of inmates' fear that such information may not remain confidential and their reluctance to seek HIV testing, ECAP feels that alternatives to HIV testing carried out by prison health-care staff would reassure inmates and reduce their fears while encouraging them to seek such testing. ECAP strongly believes that giving inmates access to HIV testing from such health-care personnel as primary-care or community clinic staff who are independent of CSC will encourage inmates to be tested and will allow them to seek care, support and treatment.

Further, ECAP was impressed by the results of an anonymous testing program in one provincial prison in Quebec, which is provided by an outside community health clinic. ECAP believes that anonymous HIV testing programs should be accessible to all inmates in federal correctional institutions. Studies have often shown higher rates of HIV infection among people seeking anonymous testing. In Ontario, after twelve months of operation, the overall positivity rate among clients of an anonymous testing program was 2.8 percent compared to 0.7 percent for nominal testing programs.[111] This indicates that many people who consider themselves at risk of having contracted HIV infection prefer this option, which guarantees the confidentiality of their medical information.

Discrimination

ECAP feels that fear of discrimination by fellow inmates or by staff would be greatly reduced and that inmates would be encouraged to seek testing if testing were undertaken by health-care personnel independent of CSC, and if anonymous testing were accessible to inmates.

RECOMMENDATIONS

2. **(1) ECAP recommends that, as is the case with testing outside correctional institutions, testing should be readily accessible to all inmates in federal correctional institutions at their own request.**

   (2) Testing should always be voluntary – with the express consent of the inmate – and should always be accompanied by counselling and education before and following testing.

[21] For more details, see *HIV/AIDS and Prisons: Background Materials.* Appendix 6: Results of the Inmate Questionnaire

(3) All inmates should be made aware that HIV antibody testing is available, in particular on entry into prison, but also while in custody and regardless of whether or not they have been exposed to HIV (i.e., have engaged in "high-risk activities").

(4) All inmates should have access to HIV testing from CSC health-care personnel as well as from primary-care or community clinic personnel who are independent of CSC.

(5) All inmates should have access to anonymous HIV testing.

3. OFFENDER MEDICAL INFORMATION

A question closely related to that of testing of inmates for antibodies to HIV is that of confidentiality and disclosure of offender medical information.

CURRENT SITUATION

Protecting confidentiality and preventing discrimination

In the context of federal prisons, Commissioner's Directives expressly affirm the confidentiality of offender medical information. Directive 835 states:

> 12. Offenders have the same rights to confidentiality of information obtained by a health care professional as exists in the general community.

Further, Directive 821 provides as follows:

> 19. All diagnosis of HIV infection shall be noted on the problem sheet of the medical record. Once informed, health care staff shall comply with Commissioner's Directive No. 835 which governs the confidentiality and disclosure of any information obtained by a health professional.
>
> 20. Upon transfer to parole jurisdiction, health care staff shall, with the inmate's consent, ensure that arrangements have been made for follow-up with an appropriately qualified community physician.
>
> 21. The HIV status of an inmate is medical confidential [sic]. This information shall not be released to supervisory/agency staff without the inmate's consent.

Disclosure of medical information

The confidentiality of offender medical information is not considered to be absolute. With regard to disclosure of this information, Commissioner's Directive 835 states:

> 12. [I]t is the responsibility of a health care professional, when there is reasonable cause to believe that the offender's intentions or possible actions may constitute a threat to the safety of him/herself or others, to provide information to the appropriate personnel without the offender's consent.

Similarly, Commissioner's Directive 821 provides:

> 21. [I]f there is cause to believe that an offender's actions may constitute a danger to himself or others, and in accordance with the *Privacy Act*, health care staff shall provide information to the appropriate personnel without the offender's consent.

THE DEBATE

From the foregoing, it is clear that a general principle of confidentiality of personal medical information – namely that such information is confidential between the person and the person's medical practitioner – applies to the personal medical information of offenders in the correctional system. This means that disclosure of this information without the offender's consent is

unwarranted unless it is authorized by law and is ethically justified.

The text that follows examines two aspects of the confidentiality of the personal medical information of offenders. First, because CSC Directives do not address this issue, what measures should be taken to protect this information? Second, recognizing that the right to confidentiality is not absolute and that disclosure of inmates' medical information may sometimes be justified, the issue of disclosure is also addressed. The issue of disclosure of personal medical information has been analyzed in detail by ECAP, and a paper summarizing this analysis is included in *HIV/AIDS and Prisons: Background Materials* as Appendix 7. This paper, entitled "Disclosure of Offender Medical Information: A Legal and Ethical Analysis," examines, first, whether or not medical information pertaining to federal inmates – information that is considered confidential between inmate and medical staff – may be disclosed absent the inmate's consent. Second, it examines what conditions or criteria determine whether or not disclosure would be legally and ethically justifiable, and what conditions apply to disclosure when it is justified. Third, it examines specific situations in which a claim for disclosure may arise.

Protecting confidentiality and preventing discrimination

In 1992, the National Advisory Committee on AIDS (NAC-AIDS) recommended that the confidentiality of all HIV-related information in correctional facilities be strictly maintained, for two reasons. First, NAC-AIDS was concerned that, if the confidentiality of this information was violated, infected inmates would be placed at considerable risk of discrimination and would likely have to be removed from the general inmate population. Second, NAC-AIDS found that "there is no reason for this information to be made available either to other inmates or to the non-medical staff of the correctional facilities." Consequently, NAC-AIDS recommended that the Solicitor General implement additional measures to secure the confidentiality of all HIV-related information in correctional facilities. In particular, NAC-AIDS felt that it was necessary "to provide for disciplinary action against any employees found in violation of HIV-related confidentiality provisions."[112]

The Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all inmates in federal penitentiaries have access to "counselling and testing for HIV infection on ... inmate request, with confidentiality of results."[113]

The Prisoners with AIDS/HIV Support Action Network (PASAN) stated that "[t]he confidentiality of all prisoners' HIV-antibody status (whether positive or negative) must be respected" and that "[s]taff members who break the confidentiality of prisoners should be disciplined and/or fired."[114] It further recommended that staff be trained to protect the privacy of inmates' medical data and that work rules prohibiting release of HIV-related information be strictly enforced; that HIV-positive prisoners be consulted and their consent obtained before medical information is given to prison authorities or support workers; that prison administrators and staff have access to the HIV-antibody status of prisoners only when it is absolutely necessary and with the prisoners' consent; that when such information is shared, it must be held in the strictest confidence; and that this policy and the penalties for breaking it be made widely known in the prison community among both staff and inmates.[115]

In Australia, the New South Wales Anti-Discrimination Board recommended that "[p]rocedures for the protection of confidentiality regarding the HIV status of any inmate should be established in every custodial institution, and breaches of confidentiality should be dealt with as breaches of discipline under the relevant legislation."[116]

In the United States, the National Commission on AIDS recommended that staff should be trained to protect the privacy of inmate medical data and that work rules prohibiting release of HIV-related information should be strictly enforced.[117] Similarly, the proposed HIV Policy for the District of Columbia Department of Corrections establishes

strict rules for the protection against disclosure of medical records. In particular, the policy states that "[a]ny unauthorized disclosure of medical records by DOC [District of Columbia] staff will result in immediate disciplinary proceedings," that "[p]ossession of prisoner medical records by unauthorized DOC staffpersons will result in an automatic unpaid suspension" and that "[d]isclosure of information contained in prisoner medical records to another unauthorized staffperson or to another prisoner will result in termination of employment."[118] In addition, the policy states that to protect prisoner records from unlawful disclosure, all information identifying a prisoner as HIV-positive will be contained in the prisoner's medical files. All prisoner medical files will be immediately identifiable as medical files, will be conspicuously coloured and sealable, will be stored in locked file cabinets, and access to any prisoner's file will be limited to the following categories of individuals: the DOC medical, dental, or mental health staff directly responsible for providing care to that prisoner; a consulting specialist or outside health-care provider to whom the prisoner is referred for treatment or evaluation; or specifically identified individuals to whom the prisoner has permitted disclosure after providing written, informed consent. The policy further states that medical staff will not examine or question a prisoner about HIV-related issues or discuss the HIV-related health-care status of a prisoner without his or her consent, while in the presence or within earshot of other prisoners or DOC staff who are not directly providing HIV-related care to the prisoner.

In France, the National Commission on AIDS [TRANSLATION] recently released a report on prisons, HIV/AIDS, and confidentiality.[119] The report contains a comprehensive analysis of confidentiality with respect to HIV/AIDS in French prisons. It acknowledges the importance of respecting confidentiality in prisons as outside, identifies obstacles to ensuring confidentiality in the prison environment, and includes a number of recommendations on how to overcome these obstacles. Emphasis is placed on education of health-care staff, correctional officers, and administrative staff about the importance of respecting the confidentiality of medical information.[120]

The importance of protecting confidentiality in relation to HIV/AIDS is also acknowledged in the World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* which affirm:

> 31. Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents.[121]

The respondents to ECAP's *Working Paper* generally agreed with ECAP's conclusions with regard to protecting confidentiality and preventing discrimination in correctional institutions. Importantly, the Office of the Privacy Commissioner of Canada expressed its support for ECAP's conclusions.[122] Support also came from within correctional institutions: for example, the warden of one institution, after extensive consultation with an inmate group and staff, stated that all conclusions with regard to confidentiality "put forth by ECAP were agreed upon by the Inmate group and CSC staff."[123] One respondent expressed his concern that ECAP may not have considered the issues involving protection of confidentiality that arise when inmates are taken on medical escorts. In particular, the respondent, an inmate with HIV infection, pointed out that staff escorting an inmate on a medical pass are instructed to remain within "sight and sound" of the inmate. In practice, this means that an inmate's medical condition will become known to the staff escorts. Inmates are concerned that staff escorts will share the information with fellow staff. The respondent noted that he himself had once overheard an escort informing a nurse at the local hospital that the inmate was HIV-positive. Another situation in which protection of confidentiality is difficult occurs when inmates who are HIV-positive are taken to medical facilities that specialize in the treatment of people with HIV infection or AIDS.

The respondent pointed out that this will, in itself, be sufficient to disclose an inmate's condition to escorting staff. With regard to ECAP's conclusion that inmates or staff who wrongfully harm or discriminate against inmates with HIV infection or AIDS should be disciplined, one respondent emphasized that it will be important that a collective effort of CSC staff, prisoners, and community groups be undertaken to define what constitutes wrongful discriminatory behaviour, and that both staff and prisoners need to be made aware that sanctions will be enforced should discrimination occur.[124] Some respondents expressed doubts about whether inmates should be "encouraged" to disclose their HIV status when the benefits from disclosure may seem questionable.

Disclosure of medical information

Staff in federal penitentiaries have often claimed that they "need to know" the HIV status of infected inmates in order to take adequate precautions to protect themselves and their families. Of 450 staff who responded to this question on ECAP's questionnaire, 81.6 percent thought that staff "needed to know" prisoners' HIV status.[22] In particular, some staff have maintained that the use of "universal precautions" is not practical and that it is unrealistic to believe that protective measures that can prevent HIV transmission in penitentiaries can be applied universally. They have also argued that knowing a particular inmate is HIV-infected would protect them because they would then handle the known infected offender with increased caution. It has also been claimed that health care staff may disclose medical information to a staff member or to an inmate who has suffered a significant exposure to bodily fluids or blood of an inmate who is HIV positive or infected with hepatitis B; that health care staff may share information about an inmate's HIV or hepatitis B status with the warden of the institution, or may even be required to do so; that the HIV status of an offender may be released to a case management officer or parole officer without the offender's consent; and that a parole officer may release information about an offender's HIV status to community authorities without the offender's consent.[125]

In the opinion of the Privacy Commissioner, there may be a merit in a policy that allows disclosure where an infected inmate's conduct threatens others, for example, through unsafe sexual practices or the sharing of needles.[126] In the Privacy Commissioner's report, *AIDS and the Privacy Act*, a distinction is made between disclosure of offender medical information in order to prevent HIV exposure among offenders and disclosure to prevent HIV exposure of prison staff. The report states that disclosure to staff "remains a question."[127] In part, this reflects a concern of the Privacy Commissioner that corrections officers may negligently pass the information to other inmates. The report recognizes the risk to staff of being exposed to HIV, stating that "some corrections officers may fear that inmates will attempt to infect them, given the hostile relations between the two groups."[128] However, it concludes that "[h]ow significant a risk this is must be assessed before a decision is made about informing corrections officers of an inmate's HIV infection."[129]

Claims that staff "need to know" an offender's medical information in order to be able to protect themselves against infection would seldom appear to be justifiable. As PASAN has pointed out, it is an illusion to think that staff and inmates would be protected from AIDS by knowing every inmate's HIV status. It would in fact be practically impossible to be certain of everyone's status because the results of the HIV-antibody test are not always 100 percent accurate. Tests must be repeated after a period of approximately six months, during which time the individual must not have participated in any high risk activities. Because the test measures the presence of antibodies to HIV, not the presence of the virus itself, people who have recently (within the past six months) been infected may not have

[22] For more details, see *HIV/AIDS and Prisons: Background Materials*. Appendix 5: Results of the Staff Questionnaire.

developed antibodies to the virus and may therefore test negative. There can also be false negative and false positive results to the test. Because of this, public health campaigns argue that we can only assume that everyone, including staff, could be HIV-positive. The proper use of universal precautions when dealing with anyone's potentially infectious bodily fluids is the only way to meet workplace safety concerns effectively.[130]

PASAN therefore recommended that "HIV-related information in the possession of medical providers should be released to prison authorities only under extraordinary circumstances and only with the consent of the prisoner."[131]

At a workshop on HIV in the workplace held by CSC Ontario Region on 13 October 1992, one working group composed of members of the regional health-care staff discussed "the conundrum of confidentiality." The working group acknowledged that there is considerable pressure on health-care staff to let security staff know which inmates are HIV-positive, and found that the concept of universal precautions is not widely understood by security staff. The findings of this working group may be summarized as follows: (1) Inmates are very interested in knowing which other inmates are HIV-positive. (2) There is considerable pressure on health-care staff to let security staff know which inmates are HIV-positive because the concept of universal precautions is not widely understood by security staff and therefore health-care staff are sometimes badgered to release information on the HIV status of various inmates. (3) HIV testing appears to be readily available to inmates who wish it. (4) Some concern was expressed concerning who has access to inmates' HIV-status and health records. (5) Some health-care staff feel that a certain "comfort level" will be provided by identifying which inmates are HIV-positive and which are not. This is incompatible with the concepts of universal precautions. (6) It was acknowledged that universal precautions mandates that all health-care providers use the same precautions in providing services to all patients. (7) It is important that the HIV status of an inmate be made available to the appropriate medical staff so that they may implement the required medical therapy. (8) Questions were raised concerning how a health-care worker would determine the HIV and hepatitis B status of an inmate were that health-care worker to be exposed to that inmate's blood, and concerning who would have access to this information and by whose authority serological testing would be performed on that inmate's blood. It was acknowledged that the consent of the inmate would be required.[132]

Internationally, as stated by Harding and Schaller, "[t]he superficially attractive doctrine of communicating the results to prison administrators on a need-to-know basis is being recognized ... as unrealistic,"[133] and staff are informed of inmates' HIV status only in a minority of prison systems.[134] For example, in England and Wales the Viral Infectivity Restrictions according to which prisoners with HIV infection had a red V.I.R. stamped on their personal records are now being phased out.[135] In the United States the National Commission on AIDS stated that "[t]est results should never be made available to any prison employee, even prison medical employees, without the specific, written informed consent of the prisoner."[136] The National Prison Project recommended that "[e]fforts should be made to ensure the highest degree of confidentiality concerning a prisoner's HIV status." It continued by saying that "need to know laws and other regulations are unnecessary and generally a response by miseducated corrections staff." The Project concluded:

> A person's medical status should be a private matter between the prisoner and his or her medical doctor. It is not necessary for the parole board, future employers, judges or corrections staff to know a prisoner's HIV status. The general release of this confidential medical information routinely leads to discrimination and stigmatization of the HIV-infected prisoner.[137]

This is consistent with the Word Health Organization's *Guidelines on HIV Infection and AIDS in Prisons*, which contain the following

provisions relating to disclosure of HIV status of inmates:

32. Information regarding HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff, applying to disclosure the same principles as those generally applied in the community. Principles and procedures relating to voluntary partner notification in the community should be followed for prisoners.

33. Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoners' files, cells or papers to indicate their HIV status.[138]

Most of the respondents to ECAP's *Working Paper* were supportive of ECAP's conclusions with regard to disclosure of offender medical information. One respondent suggested that it will be important to define what constitutes an "exceptional case," in which disclosure of an offender's medical information may be justified. This respondent recommended that CSC staff, prisoners and people independent of CSC jointly define such cases and that, in each case in which medical information is disclosed, a written statement justifying the disclosure be provided to healthcare staff and to the inmate involved, "so that s/he has evidence for legal recourse if the need should arise."[139]

ECAP'S ASSESSMENT

Protecting confidentiality and preventing discrimination

Protecting confidentiality in the prison system raises very complex issues. Outside prisons, everybody assumes that information about themselves relating to medical treatment and their health status is confidential and that it will be made available to others only when they have consented to its disclosure. Moreover, outside prisons, information may be disclosed to some people without others knowing this information – in particular the community in which people live or with which they interact closely. In contrast, it has been stated that confidentiality cannot be adequately guaranteed in prison.[140] Indeed, as noted by the French National Commission on AIDS, [TRANSLATION] "the very idea of confidentiality in a correctional environment was until recently difficult to conceive. Traditionally, prison logic involves the absence of confidentiality within the closed environment of the prison. The implementation in the prison world of a medical logic indissociable from the idea of medical confidentiality thus seems conflictive, if not inconceivable.[141] It has been said that "when an HIV-positive person is in prison, her or his health status is usually circulated among both the guards and the prisoners."[142] There are many reasons for this: (1) Information about HIV status cannot at present be generated in penitentiaries in such a way that only the affected inmate controls its communication, since anonymous testing is currently unavailable in federal penitentiaries. (2) Self-disclosure of HIV status by infected inmates appears to be frequent, often made in order to obtain care, counselling or support that would not be available without such disclosure. (3) In the closed environment of the prison, personal information spreads easily and quickly, and any inmate whose HIV-antibody status is known to anyone within the system must anticipate that it will become common knowledge. (4) Although Commissioner's Directives stress the importance of maintaining the confidentiality of the HIV status of inmates, this information may sometimes be disclosed without the affected prisoner's consent.

ECAP commends CSC for recognizing that "offenders have the same rights to confidentiality of information obtained by a health professional as exists in the general community" (Directive 835, section 12). At the same time, as the British Columbia Civil Liberties Association stated:

> We are aware that the prison "grapevine" system is an extremely efficient conduit for information. Little goes on in prisons which is not almost immediately known by almost all inmates and staff. This makes the confidentiality of an inmate's HIV status difficult to maintain. However, strict guidelines for nondisclosure of HIV information at the source, the health unit, coupled with inmate and correctional staff education, should eradicate much of the problem.[143]

In view of the possibilities for disclosure of personal medical information of inmates and the potential harms from such disclosure, and in order to prevent breaches of confidentiality, the Committee concluded that it is essential that CSC have specific policies and procedures that will restrict access to, and allow for better protection of, confidential medical information. These should also establish strict guidelines for protection of medical information during medical escorts. Further, they should ensure that breaches of confidentiality by staff are dealt with as breaches of discipline.

In addition, because protecting confidentiality is more difficult in the closed environment of correctional institutions, ECAP concluded that efforts to protect confidentiality must be accompanied by efforts to protect inmates with HIV infection or AIDS against discrimination. ECAP found no evidence of systemic discrimination against inmates with HIV infection or AIDS in federal penitentiaries. In particular, HIV-positive inmates are usually housed in the general prison population, can participate in the same activities as other inmates, and have the same access to health care as other inmates. ECAP was often told that inmates' and staff's attitudes and behaviour toward HIV-positive inmates are changing, that some abuses that may have occurred early in the HIV pandemic no longer occur, and that acceptance and support are increasing. This is particularly true where staff and inmates have had contact with known HIV-positive inmates. However, ECAP sometimes heard that HIV-positive inmates have been discriminated against or have been afraid to seek testing, support and counselling because of the fear that their HIV status would be disclosed and that they would be exposed to discrimination by fellow inmates and by staff. Although it commends CSC and especially staff for their efforts, ECAP believes that more could be done to reduce inmates' fears and to ensure that infected inmates will not be discriminated against. The primary effort for achieving this is education, so that inmates and staff may overcome the fears and prejudices that are often the basis of discrimination. Importantly, ECAP feels that inmates should be able to reveal their HIV status to fellow inmates and to staff without fear so that inmates can receive support, care and treatment. In order to allow them to "come out" as HIV-positive, measures should be undertaken to ensure that inmates who are HIV-infected will not be wrongfully discriminated against.

Disclosure of medical information

The claim of staff that they "need to know" the HIV status of infected inmates raises many complex issues. There are two main situations in which claims for disclosure arise: (1) disclosure preceding exposure to HIV, in order to prevent exposure and possible HIV transmission; and (2) disclosure following exposure to HIV. ECAP has devoted much time to an examination of these issues, acknowledging that staff's concerns for their safety in the workplace have to be taken very seriously. At first, the claim that staff "need to know" an inmate's HIV status in order to be able to better protect themselves against HIV transmission seemed irreconcilable with demands for better protection of the confidentiality of personal medical information. However, ECAP soon realized that, although prisoners' interest in maintaining their test results confidential and the interest of staff in protecting themselves from exposure to HIV are often perceived to conflict, they are in reality compatible. Further, whatever is done to reduce the levels of infection within an institution will protect everyone in the institution, both staff and inmates.

ECAP's examination of the legal and ethical issues raised by the disclosure of an inmate's personal medical information absent the inmate's consent revealed that such disclosure is rarely justifiable.[23] In most situations such disclosure cannot be considered necessary and its efficacy would appear to be questionable. Often, disclosure would appear to be counterproductive or harmful, in excess of any benefits or potential benefits that might result from it. This follows from the fact that most measures that can be undertaken to prevent exposure to and infection with HIV have to be undertaken regardless of whether an inmate or staff member is or is not known, to staff, wardens, or inmates, to be infected with HIV.

In order to protect themselves, prison staff have to apply precautions universally. Arguments that "extra precautions" could be taken with known HIV-positive inmates are misguided because the concept of universal precautions requires that the same precautions be taken for every inmate, whether or not the inmate is known to be seropositive. ECAP was often told by staff that applying precautions universally in the prison setting is impossible or impractical. However, experience in the health-care setting has shown that people can and must learn to apply precautions universally. For example, in hospitals, where the risk of exposure to HIV is much higher than in prisons, it has long been understood that disclosure of the HIV status of patients would not increase staff safety.[144] Consequently, the HIV status of patients and doctors is not revealed to others, and strict adherence to universal precautions is enforced. ECAP believes that, were staff to be routinely informed about prisoners known to be HIV-infected, it would create a false sense of security; without all prisoners being tested repeatedly, staff would know of only a few of the infected prisoners. Further, ECAP is concerned that if the HIV status of seropositive offenders were disclosed to staff, fewer offenders would come forward for testing or self-disclose their positive HIV status. ECAP was told on numerous occasions that most seropositive offenders will sooner or later self-disclose their HIV status to fellow offenders and to staff. Such disclosure is voluntary, and offenders will wait until they feel "ready" to self-disclose; but were disclosure to staff to become an automatic by-product of a positive test result for HIV, many offenders who now volunteer to be tested (and at some point self-disclose) would likely not choose to be tested in the first place. As the Krever Commission stated:

> [T]he primary concern of physicians, hospitals, their employees and other health-care providers must be the care of their patients. It is not an unreasonable assumption to make that persons in need of health care might, in some circumstances, be deterred from seeking it if they believed that physicians, hospital employees and other health-care providers were obliged to disclose confidential health information to the police in those circumstances.[145]

Similarly, it would not be an unreasonable assumption that inmates would be deterred from seeking testing were health-care staff obliged to disclose positive test results to other staff. In the end, staff would very likely know of fewer HIV-positive inmates than under the present policy. For all these reasons, ECAP agrees with a study on HIV/AIDS in Australian prisons which concluded that, while the desire of correctional officers to know the identity of seropositive prisoners may be understandable, the knowledge may in fact be dangerous to the officers as well as detrimental to the prisoner:

> Custodial officers may be lulled into a false sense of security with regard to prisoners believed to be HIV negative. Because of the unreliability of the test (the "window" period) and the possibility of recent infection there is a risk that such prisoners may be seropositive. Universal blood and body fluid precautions provide a much higher degree of protection for custodial staff.[146]

[23] For more details, see *HIV/AIDS and Prisons: Background Materials*. Appendix 7: Disclosure of Offender Medical Information: A Legal and Ethical Analysis

ECAP also agrees with the policy of the Detention Branch of the Quebec provincial prison system, which states as follows:

> [TRANSLATION]
>
> 5.7 The rules respecting the confidentiality of medical files apply in respect of every incarcerated person, in particular when that person has been tested for antibodies to HIV or hepatitis B.

However, two exceptions to this rule have been provided for:

(1) When an incarcerated person relieves a health professional of the patient-physician privilege.

(2) When a medical practitioner concludes that an incarcerated person known to be infected with the AIDS or hepatitis B virus constitutes a risk of infection because of dangerous or irresponsible behaviour toward staff and/or other incarcerated persons.

ECAP recognizes that there are some situations when disclosure that an inmate suffers from an infectious disease might be justifiable, such as when an infected inmate threatens to harm someone and there exists a significant or probable risk of serious physical harm to that person.[147] Nonetheless, disclosure remains an exception to the principle of confidentiality. ECAP has examined some of the situations in which disclosure may be justifiable as an exception to respect of confidentiality.[24] However, ECAP feels that there is an urgent need to clearly define these situations.[25]

RECOMMENDATIONS

PROTECTING CONFIDENTIALITY AND PREVENTING DISCRIMINATION

3. (1) ECAP recommends that procedures be reviewed in every federal correctional institution to ensure that the confidentiality of medical information is protected, in particular information regarding the HIV status of inmates.

(2) ECAP recommends that CSC's policy according to which breaches of confidentiality by staff are breaches of discipline be rigorously enforced.

(3) ECAP recognizes both the need for and potential benefits to inmates from disclosing their HIV status to other inmates and staff. ECAP recommends that, in order to encourage inmates to disclose and to obtain the benefits from disclosure, any inmate or staff who wrongfully harms or discriminates against inmates with HIV infection or AIDS be disciplined.

(4) ECAP recommends that Commissioner's Directives be revised to include a clear statement that any workplace behaviour that wrongfully discriminates against inmates with HIV infection or AIDS will not be tolerated and that those involved in such behaviour will be subject to disciplinary action.

DISCLOSURE OF OFFENDER MEDICAL INFORMATION

(5) ECAP recommends that every inmate's personal medical information remain confidential between medical personnel and the inmate and should not be disclosed without the inmate's consent.

[24] See *HIV/AIDS and Prisons: Background Materials*. Appendix 7: Disclosure of Offender Medical Information: A Legal and Ethical Analysis.

[25] An Interdepartmental Committee on Human Rights and AIDS was established in May 1993. It is currently studying issues relating to testing and confidentiality.

Only in exceptional cases will such disclosure without the inmate's consent be justifiable, and then only when it is clearly necessary, is likely to be effective, and is the least invasive and restrictive means available to prevent harms that cannot otherwise be prevented. CSC, in collaboration with inmates and independent experts, should clearly define such exceptional cases.

(6) ECAP recommends reliance on the stringent and universal application of procedures and practices that can prevent HIV transmission as the most effective means of preventing HIV transmission in correctional institutions, as opposed to reliance on knowing who in a correctional institution may or may not be infected. For both staff and inmates, the universal application of precautions to prevent HIV transmission, and access to the means to do so, are essential.

4. HOUSING AND ACTIVITIES

CURRENT SITUATION

With regard to the placement of inmates with HIV infection or AIDS, Commissioner's Directive 821 states that

5. Once an inmate has been placed in an institution he/she shall be housed as follows:

a. if the inmate has antibodies to HIV or is diagnosed as having ARC, attempts shall be made to place him/her in the general population;

b. if placement in the general population is not feasible, attempts shall be made to place the inmate in protective custody;

c. if protective custody is not feasible, the inmate shall be placed in administrative segregation; and

d. if the inmate has AIDS he/she shall be housed in the health care centre.

According to section 6 of the Directive,

> case-by-case decisions regarding institutional placement may be necessary to accommodate the specific medical and non-medical characteristics of each particular case.

With regard to activities, sections 7 and 8 of the Directive read as follows:

7. Inmates with suspected HIV infections or diagnosed with HIV infection shall not be managed differently from other inmates unless medically indicated.

8. The Director may decide to isolate an inmate to maintain the security or good order of the institution.

This Directive, like most provincial prison policies, provides that attempts shall be made to house infected inmates among the general prison population and that they be able to participate in all prison activities, but the exceptions to this rule are broadly phrased and there are no decision-making criteria.

A revised version of Directive 821 (pending approval) does not contain very specific provisions either, but it nevertheless constitutes a significant step in the right direction. In particular, sections 3 and 4 of this Directive state:

3. Inmates who have AIDS or who have antibodies to HIV shall be placed in an institution in the same manner as all other inmates who do not have indications of the disease.

4. Every attempt will be made to house inmates who have AIDS or have antibodies to HIV in the general population.

The revised Directive emphasizes that any placement other than in the general population will be an exception rather than the rule. In contrast, the current Directive states only that "attempts

shall be made" to place infected inmates in the general population, and in principle it allows for other kinds of placement and gives prison authorities wide discretionary power.

With regard to inmates who have AIDS, the current Directive states that they shall be housed in the health-care centre. In contrast, under the revised Directive the same considerations that apply to inmates with HIV infection also apply to inmates with AIDS. In particular, section 6 states:

> 6. The inmate who has antibodies to HIV or has AIDS will not be transferred to the health care centre unless ordered by the institutional physician for medical reasons.

Thus, under the revised Directive the general approach is to place inmates with HIV infection or AIDS in the general population. However, this principle is limited by section 5 of the Directive, which states:

> 5. If placement in the general population is not feasible, protective custody or administrative segregation will be considered.

This exception is very broadly phrased and contains no decision-making criteria.

With regard to activities, the revised Directive reads as follows:

> 7. Inmates suspected or diagnosed with HIV infection shall be managed in the same way as other inmates unless medically indicated.
>
> 8. Where an inmate who has HIV infection cannot be maintained in the general population, every effort shall be made by staff to keep the inmate productively occupied.

In practice, inmates with HIV infection or AIDS have sometimes been segregated on the basis of their being infected. This has mostly occurred in provincial institutions. For example, the British Columbia Civil Liberties Association received a complaint from an inmate in a British Columbia remand centre who told prison officials that he might be HIV-positive. The inmate alleged that he was placed in 24-hour lock-up for 16 days despite two negative HIV tests, was allowed visits only when separated by a plastic window from visitors, was accompanied by guards in rubber gloves when out of his cell, and that his friends were denied visits "because he has AIDS."[148] In another case, an inmate in the Metro Toronto West Detention Centre claimed that he was placed in medical segregation for five days after telling correctional officers that he is HIV positive.[149] It has been alleged that prisoners with HIV infection or AIDS were being isolated from the rest of the population in provincial remand centres as late as 1989.[150]

There are sporadic reports of such isolations in federal penitentiaries. While the Prisoners with AIDS/HIV Support Action Network (PASAN) claims that the isolation of HIV-positive prisoners has been an all-too-frequent reality, if not official policy, of both provincial and federal prisons,[151] the statistics provided by CSC on the location of known offenders with HIV infection or AIDS demonstrate that cases of segregation, disciplinary dissociation or protective custody of inmates with HIV infection or AIDS are rare. For example, in October 1992 a total of 59 inmates known to have HIV infection and three inmates with AIDS were incarcerated in federal institutions. Of the 59 inmates with HIV infection, 55 were housed in the general population, two in health-care centres, one in disciplinary dissociation, and one in protective custody. Of the three inmates with AIDS, two were housed in the general population and one in a health-care centre. From January to October 1992 there were never more than five inmates with HIV infection in federal correctional facilities who were not located in the general population.

THE DEBATE

In many countries the initial response to HIV/AIDS in prisons was to isolate and segregate prisoners with HIV infection. This was done at a time when there was misunderstanding and a lack of education about how HIV is and is not transmitted.

Isolation and segregation continue in some prison systems – for example, in many systems in the United States. In contrast, a recent survey of selected prison systems revealed that 23 of 31 European prison systems and four of seven Australian states have clear "no segregation" and "normal housing" policies for HIV-infected prisoners.[152] Yet the survey also revealed that, even in the systems that have non-discriminatory housing policies, prisoners with HIV infection may still be excluded from certain activities such as working in kitchens or infirmaries.

As Harding and Schaller have pointed out, the debate about segregation and participation in work activities by HIV-infected prisoners has been complicated by two factors. The first is the assertion that such prisoners require a protective environment in their own interests, i.e., freedom from harassment by other prisoners and improved hygienic conditions, medical care and nutrition. The second is the desire to protect the general prison population from violent or sexually predatory HIV-infected prisoners.[153]

In Canada it is generally agreed that inmates with HIV infection or AIDS should normally be housed with the general inmate population.[26] A decision by the Ontario Court of Justice has reaffirmed that segregation of inmates with HIV infection is justified only in exceptional cases. The Court held that isolation might be warranted not because of an inmate's HIV infection but because of behaviour that could expose others to HIV.[154]

In practice, segregation or isolation is clearly the exception rather than the rule in federal institutions. Nevertheless, there have been examples of unwarranted segregation, and there is concern that segregation may be practised arbitrarily and that policies may be applied in a haphazard and inconsistent manner.

In response to this, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all inmates be housed with the general inmate population "unless [segregation is] required for the ... inmate's own well being."[155] The Federal Centre for AIDS Working Group on HIV Infection and Mental Health suggests that, "[w]henever possible, correctional facilities house inmates with HIV disease with the general prison population where they have access to the full range of programs and activities in the institutions."[156] Similarly, PASAN stated that, as a matter of principle, "[p]risoners with HIV/AIDS should not be involuntarily isolated or segregated"[157] because it is not justifiable, nor is it in the best interests of either the isolated inmate or the general population. It emphasized that special housing arrangements should be considered only when inmates themselves request them, such as when their health may be jeopardized by viruses or opportunistic infections transmitted by others in the population. In other words, "[s]pecial housing ought to translate into supportive medical care, and not punishment or hardship."[158] Involuntary isolation "serves no one's interests" and "presents to the prison population a false sense of security – that infectious people are removed from their lives and that therefore they need not take proper safe sex and safer drug precautions."[159]

Similar recommendations were made in the United States, where the National Prison Project stated that "[t]he only time that a prisoner should be isolated or segregated is when he or she exhibits predatory or violent behavior toward other prisoners or staff. Prisoners who are prone to violence whether HIV positive or negative should be isolated. HIV positive prisoners who are removed from the general population after engaging in "high risk" behavior should receive AIDS counselling and education and be given the same opportunity as non-HIV positive prisoners to return to the general prison population."[160]

[26] However, in a study of inmates' knowledge, attitude and behaviour with regard to HIV/AIDS undertaken by Toepell in two provincial institutions in Ontario, slightly over half of the interviewed inmates, when asked where inmates with HIV infection should be placed, suggested a separate or special unit/range for HIV positive inmates. Only 11 percent of inmates responded that they should be placed in the general population. For more details, see Toepell, infra, endnote 108 at 36-37.

This is consistent with the World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons*, which contain the following provisions with regard to the management of HIV-infected prisoners:

27. Since segregation, isolation and restrictions on occupational activities, sports and recreation are not considered useful or relevant in the case of HIV-infected people in the community, the same attitude should be adopted towards HIV-infected prisoners. Decisions on isolation for health conditions should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public health standards and regulations. Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds, and as provided for by public health standards and regulations. HIV-infected prisoners should have equal access to workshops and to work in kitchens, farms and other work areas, and to all programmes available to the general prison population.

28. Isolation for limited periods may be required on medical grounds for HIV-infected prisoners suffering from pulmonary tuberculosis in an infectious stage. Protective isolation may also be required for prisoners with immuno-depression related to AIDS, but should be carried out only with a prisoner's informed consent. Decisions on the need to isolate or segregate prisoners (including those infected with HIV) should only be taken on medical grounds and only by health personnel, and should not be influenced by the prison administration.

29. Disciplinary measures, such as solitary confinement for prisoners, including perpetrators of aggressive, or predatory sexual, acts or those who threaten such acts, should be decided upon without reference to HIV status.

30. Efforts should be made to encourage among prisoners supportive attitudes – towards, for example, those affected by HIV/AIDS – in order to prevent discrimination and to combat fear and prejudice about HIV-infected people.[161]

The issue of housing was also addressed in some of the responses to ECAP's Working Paper. Without exception, respondents agreed with the Committee's conclusions.

ECAP'S ASSESSMENT

ECAP commends CSC for its practice of housing inmates with HIV infection or AIDS in the general prison population. However, more specific provisions in the prison policies concerning the placement of offenders with HIV infection or AIDS are possible with respect to minimizing the risk of unwarranted segregation. In particular, Commissioner's Directive 821 could clearly state that decisions about the segregation of inmates with HIV infection or AIDS follow the same criteria as decisions about the segregation of any other inmate. For example, if inmates are violent or predatory, their actions may justify isolation or other disciplinary measures regardless of their HIV status. This would be consistent with the decision in *Ratte*,[162] and with the World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons*. Such a change would reinforce the approach that CSC intends with its revision of the Commissioner's Directive, namely that being HIV-infected is not a basis on which to segregate inmates. It would also be consistent with the *Corrections and Conditional Release Act*,[163] which sets out guidelines concerning how and when administrative segregation is to be applied. The legislation states that segregation is only permissible when there is no other alternative, and the offenders pose a danger to themselves or others, jeopardize security, or would interfere with an investigation if left in the offender population.

ECAP considers that isolation of HIV-infected inmates should always be compatible with the guidelines contained in the *Corrections and*

Conditional Release Act and should only be considered when an HIV-infected inmate requests it or when other means such as education and discipline of fellow inmates or corrections officers have failed to protect the infected inmate.

ECAP further considers that inmates with HIV infection or AIDS should be transferred to a health-care centre only when their medical condition clearly necessitates it and when the transfer is ordered by a physician and the inmate consents to it. However, in accordance with WHO's *Guidelines on HIV Infection and AIDS in Prisons*, "[i]solation for limited periods may be required on medical grounds for HIV-infected inmates suffering from pulmonary tuberculosis in an infectious stage."

Finally, ECAP considers that HIV-infected inmates should not be excluded from any educational, job or vocational program, and in particular from working in kitchens and infirmaries, by reason of their HIV status alone.

RECOMMENDATIONS

4. (1) ECAP agrees that inmates with HIV infection or AIDS should be housed with the general inmate population.

(2) ECAP recommends that, in order to minimize the risk of unwarranted segregation, Commissioner's Directive 821 and other applicable Directives be revised to clearly state that decisions about housing of inmates with HIV infection or AIDS should follow the same criteria as those for any other inmate.

(3) ECAP recommends that Commissioner's Directive 821 be revised to clearly state that inmates with HIV infection or AIDS should have the opportunity to participate in the same educational, job and vocational programs as any other inmate.

5. EDUCATIONAL PROGRAMS FOR INMATES

5.1 EDUCATION ABOUT HIV/AIDS

CURRENT SITUATION

With regard to educational programs, Commissioner's Directive 821 reads as follows:

18. Regional Headquarters shall develop and coordinate a comprehensive educational effort directed at both staff and inmates. Specific components shall include:

a. educational materials and opportunities to be provided as part of the orientation for staff and for an inmate entering the system, and to include information on how AIDS is transmitted, infection control measures and precautions to minimize the risk of transmission of HIV; and

b. opportunities for periodic information updates to ensure staff and inmates are kept informed on developments relating to AIDS.

The revised Directive (pending approval) is very similar in wording and content, but would seem to emphasize "live" instead of written education:

16. Regional Headquarters shall develop and coordinate a comprehensive educational effort directed at both staff and inmates. Specific components shall include:

a. information on how AIDS is transmitted, infection control measures and precautions to minimize the risk of transmission of HIV; and

b. periodic information updates to ensure staff and inmates are kept informed on developments relating to HIV and AIDS.

CSC considers that providing inmates with information about the prevention and transmission of infectious diseases is of paramount importance. An educational program for inmates was initiated prior to 1985, when the first case of AIDS was identified in the federal prison system, and it has been in existence ever since. According to Dr. Jacques Roy, Director General of CSC's Health Care Services, "[t]he type, quality and quantity of material that has been made available has steadily improved as new information about AIDS and HIV has become available."[164] On entering an institution, inmates view the video "AIDS: A Bad Way to Die," and a nurse is available to answer any questions they might have. A variety of other audiovisual materials are also shown, and brochures and pamphlets, available in French and English, are used as part of the educational program. Other educational and preventive activities include counselling upon request, group discussions with an institutional physician, and seminars.[165] Representatives of community groups are sometimes invited to participate in these seminars.

THE DEBATE

The information programs concerning HIV/AIDS provided to inmates have been criticized as ineffective.[166] In particular, it has been said that "they are not likely to be effective in changing behaviour, and that they are not mandatory or even pressed upon the inmates, although the prison setting would allow for this."[167] It has also been pointed out that "information probably will not be of much use if inmates do not have the means to act on it."[168] Inmates themselves have said that educational sessions are "simply frustrating" when they get information about how to protect themselves but the means to do so are not made available to them. Zoltan Lugosi, an ex-prisoner,[27] pointed out that "[w]hile there is a need for films to educate prison workers, general populations of all prisons need explicit HIV/AIDS education presented by recognized community educators" and that since "prisoners distrust prison authorities and are unlikely to discuss proscribed activities, peer groups and programs are the best approach."[169]

The Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all inmates have access to "culturally and linguistically appropriate educational programs designed to minimize spread of the infection and provide factual information about risks and preventive measures."[170]

In its presentation to the Parliamentary Ad Hoc Committee on AIDS on 13 May 1992, the Canadian AIDS Society stated that "[n]ow is the time to develop a strategy on HIV/AIDS in prisons that will include ... effective education programs for both staff and inmates," and that both staff and inmates should be involved in the development and delivery of these programs.[171]

PASAN has recommended that HIV/AIDS education: (1) be made compulsory for all inmates; (2) be comprehensive; (3) "recognize and respond to the needs of prisoners with disabilities, from different ethnic and linguistic backgrounds, with varying language skills, and of different races, sexes, and sexual orientations"; (4) be provided through group HIV/AIDS educational sessions, and be made available to inmates individually upon their entering and exiting the correctional facility; and (5) be provided by external, community-based HIV/AIDS and health organizations.[172]

Similar recommendations can be found in the AIDS education needs assessment study undertaken by the John Howard Society of Metropolitan Toronto,[173] which examined the level of HIV/AIDS awareness and knowledge in two provincial institutions in Ontario. The study recommended that training and educational programs on HIV/AIDS be provided by individuals and organizations external to the Ontario Ministry of Correctional Services:

[27] In the *Working Paper,* Zoltan Lugosi was wrongfully referred to as an "ex-prisoner with HIV infection." The Committee had no information on Mr. Lugosi's HIV status whatsoever, and attributing HIV infection to him was entirely accidental. The Committee regrets this serious mistake.

> Continuous consultation with these organizations and community groups is critical to ensure that the program and information remains current, is unbiased, accurate, discouraging AIDS-phobic attitudes and false beliefs. The design, implementation and delivery of an AIDS educational program should be done by external health and/or AIDS experts and professionals. ... The Ministry should recognize and access the expertise and educational skills concerning HIV/AIDS which are available outside the field of corrections.[174]

The study revealed that the surveyed offenders "were keen on receiving HIV/AIDS education while incarcerated, and strongly supported initiatives to develop such a program in prison."[175] This is confirmed by the analysis of the results of the questionnaire ECAP sent to inmate committees. Without exception, all inmate committees and individual prisoners who responded to the questionnaire said that educational programs about HIV/AIDS should be made available to inmates.[28]

A second study undertaken by the John Howard Society examined inmates' knowledge, attitudes and behaviours concerning HIV/AIDS. The study revealed that surveyed inmates had a high level of awareness concerning HIV and AIDS. However, it also revealed many gaps in inmates' knowledge that were due primarily to myths and misconceptions. Further, many inmates expressed "strong AIDS-phobic and homophobic attitudes," felt threatened if fellow inmates infected with HIV were in their units or ranges, and suggested separate living arrangements in the institution for infected offenders. With regard to risk-producing behaviours in which inmates had engaged prior to imprisonment, the study results have been summarized as follows:

> Generally, prisoners only used condoms with sexual partners they did not know well, and stopped practising safer sex after an average of one month. Inmates who injected intravenous drugs tended to share their equipment, mostly with their sexual partners, and commonly cleaned the shared equipment. Prisoners with tattoos were generally unaware of the risks involved with HIV transmission when sharing tattoo guns, needles and/or inks.[176]

The study concluded that "[a]n education program should target the gaps in prisoners' knowledge, emphasize risk-reduction intervention for life in prison and outside prison, and encourage healthy attitude changes which will ultimately decrease their phobic-laden opinions."[177]

In some prisons, HIV/AIDS educational and support services are already provided by community-based AIDS organizations:

- The Kingston AIDS Project's Prison Outreach Program, funded by the federal government, provides HIV/AIDS education, support, one-on-one counselling, and advocacy to prisoners living with HIV disease. Peer education and support groups made up of inmates and sponsored by the Kingston AIDS Project operate in two correctional facilities. At one of these facilities, Kingston Penitentiary, an inmate was recently appointed Peer Health Counsellor, and his position became a full-time paid position.[178]
- In Dorchester Penitentiary, a federal institution in New Brunswick, a support group for prisoners with HIV infection or AIDS has been established with the help of the local community group SIDA/AIDS Moncton. Monthly meetings are held at the institution in an effort to disseminate information about infectious diseases, informational material has been distributed on the ranges, and seminars on HIV/AIDS have been held for inmates and for staff.
- At Matsqui Institution, a group was formed to "educate our fellow prisoners on the HIV/AIDS problem" and to "offer comfort

[28] For more details, see *HIV/AIDS in Prisons: Background Materials*, Appendix 6: Results of the Inmate Questionnaire

and support to HIV/AIDS patients within the institution."[179] The group also initiated an HIV/AIDS workshop that took place at the institution in February 1993.

- At the time of writing, an HIV and Friends Resource Group was being formed at Mission Institution.[180] The objectives of this group may be summarized as follows: (1) to advocate responsible behaviour by inmates and their families; (2) to provide information and education and to increase awareness of HIV/AIDS issues within the institution and the community; (3) with the assistance of the Vancouver Persons with AIDS Society and AIDS Vancouver, to provide peer counselling training to interested group members; (4) to provide on-call support for newly diagnosed inmates and, if required, to assist them in the initial adjustment phase; (5) to work in conjunction with the Health Care Service and the institutional psychologist in helping inmates adjust to their diagnosis; (6) to assist HIV/AIDS inmates in accessing the various support and therapy services available in the community; (7) to arrange ongoing and updated seminars for staff, inmates and their families; (8) to develop a greater acceptance and understanding of HIV/AIDS within the institution; (9) to help members, through their involvement in the Group, to develop a greater awareness of the issues raised by HIV/AIDS.[181]

Former CSC Commissioner Ole Ingstrup has said that CSC puts a high value on the information and support the various community AIDS groups can provide for offenders with HIV, and that it is CSC's feeling that inmates may be more likely to believe warnings that come from groups independent of the Correctional Service of Canada. He concluded by saying that CSC therefore counts, to a large extent, on these external groups for help.[182]

The importance of community support is also acknowledged in the revised version of Commissioner's Directive 821 (pending approval). A new section on community support reads as follows:

> 22. The Correctional Service of Canada will actively encourage community and self-help groups to provide, as appropriate, support and information to inmates with HIV infection or AIDS, and their families.

The former Minister of National Health and Welfare, the Hon. Benoît Bouchard, in a letter addressed to the AIDS Prison Group at Dorchester Penitentiary, also acknowledged "the need for and effectiveness of peer-led efforts."[183]

Internationally, there is a wide range of HIV/AIDS educational and prevention programs in prisons.[29]

In Australia, the New South Wales Anti-Discrimination Board stated that "[t]he most effective programs both of HIV education for prisoners generally, and support for HIV positive prisoners particularly are clearly those in which there is a maximum involvement of prisoners, supported by appropriately selected and adequately trained outside counsellors."[184] The Board continued by saying that, "[g]iven both the long established sense of hostility between prisoners and prison officers, and the widespread (and largely accurate) perception that confidentiality does not exist within the prison system, the use of prison officers, or even prison staff more generally, in such programs would seem unlikely to be effective."[185]

Heilpern and Egger proposed ten key elements for an educational program in prisons,[186] which may be summarized as follows: (1) AIDS education should be instituted before there are significant numbers of HIV-positive prisoners, because proactive programs are able to avert the development of serious concerns among staff and

[29] An overview of some of these programs and the steps that are being taken to maintain and enhance their effectiveness can be found in a report on AIDS Education and Prevention Programs in Correctional Institutions Worldwide, prepared by L. Fitzsimmons, University of Waterloo, for the AIDS Information and Education Services Unit, Health Promotion Directorate, Health Services & Promotion Branch, Health and Welfare Canada, 1992.

prisoners. (2) Education should be mandatory for inmates and staff. Although mandatory education is expensive and difficult to administer, the importance of AIDS education requires such measures. (3) AIDS training should be regularly presented and regularly updated to respond to changing information and often misleading media coverage. (4) AIDS education should include mechanisms that involve inmates and staff in the development and presentation of the programs. The best AIDS programs involve representatives of the target audiences in the development of AIDS education and training. Behavioural change, the primary goal of AIDS education, calls for a whole range of new strategies that may include: tailoring the format to the group; including the target group in the delivery of the information; using the informal but powerful prisoner hierarchy; making each institution responsible for its own AIDS-prevention strategies; devising an effective form of evaluation; and linking educational strategies with community programs. (5) AIDS training and education should be live. This is the single most effective format because it allows for interaction and feedback. It is also often recommended that a person with AIDS should be present because of the powerfully motivating influence of personal testimony. (6) AIDS educators should understand the prison system and foster credibility. The message should be accurate and straightforward, with no judgmental or hidden ideological content. The educational program should be in language as appropriate and nontechnical as possible. (7) Live training should be supplemented with video tapes and/or written informational materials. (8) In addition to providing basic information on the disease, AIDS education should address the specific concerns current in the prison, no matter how irrational such concerns may be. In prison, AIDS education should address the major risk factors – needle sharing, sexual activities, tattooing, and fights and other situations in which blood may be spilt. (9) There must be a high level of executive commitment. This enhances the credibility of the program; demonstrates the content of the program by way of example; and involves a pragmatic commitment at all levels in the prison administration. (10) AIDS educational programs should be rigorously monitored and evaluated in order to ensure that the objectives are being met.

In some prisons in Australia, peer education is a major component of efforts to prevent the further spread of HIV infection. In particular, the Centre for Education and Information on Drugs and Alcohol, in association with the Prison AIDS Project of the New South Wales Department of Corrective Services, developed a training manual for a National Prisons HIV Peer Education Program.[187] The manual is designed to be used by noncustodial prison staff and community educators conducting HIV peer-education training with inmates in prisons. Specifically, it is designed to enable educators to: (1) provide inmates with the knowledge and skills necessary to avoid HIV infection; (2) motivate selected prisoners to play an active role in HIV-prevention activities with other prisoners; (3) develop prisoner "peer educators" with the ability and the willingness to inform other prisoners about HIV transmission and about safer sex and safer drug-use practices; (4) assist peer educators to develop the skills and willingness to actively support inmates who are HIV-positive; (5) establish a support infrastructure of prison management, custodial staff, noncustodial staff and prisoners who will work together to actively facilitate all HIV-prevention activities; (6) develop an understanding of and a sensitivity to the particular learning needs of diverse groups of prisoners, in particular those with a developmental disability, those from non-English speaking backgrounds, Aboriginal prisoners, and women prisoners; (7) access information, resources and support.

Overall, this HIV Peer Education Program "aims to prevent the spread of HIV amongst the inmate population by enabling prisoners to obtain the knowledge, skills and attitudes needed to avoid infection."[188] This is achieved by directly involving prisoners, so that they "own" the process of HIV/AIDS prevention within the prison system; establishing structures in prisons for providing long-term support to prisoners' self-management in preventing the spread of HIV/AIDS; and providing comprehensive HIV educational programs that are consistent with the traditions

and cultures already established in the prison system. As stated in the manual, the "Peer Education Approach to preventing the spread of HIV/AIDS aims to build and reinforce prisoners' ability and motivation to manage their own health and well being."[189]

The document continues by saying:

> The prison setting is special. It is necessary to recognize and then positively tap into the power of the prison culture. HIV education strategies are unlikely to succeed if they are imposed from a central authority. If they are going to become part of the culture of both inmates and staff, they need to evolve in a way that will be relevant and acceptable to the particular gaol.[190]

Several reasons are given for why peer education is so effective: (1) Because HIV transmission in prison often involves illegal practices, the Peer Educator may be the only person able to speak candidly to other inmates about HIV transmission. (2) Peer Educators' input is not viewed with the same suspicion as the "propaganda" from the prison hierarchy. (3) Peer Educators are more likely to be able to realistically discuss the alternatives to risk behaviour that are available to inmates. (4) They are more likely to be able to respond to issues as they arise and in an ongoing way. (5) They are able to judge which educational strategies would work within their prison and link HIV/AIDS prevention to the existing culture and informal power structure.[191]

Prisoners' AIDS committees operating in prisons in New South Wales impart knowledge of HIV/AIDS prevention to other prisoners. Their methods include group sessions, pamphlets, posters, HIV/AIDS knowledge-based competitions, plays, video scriptwriting, and musical compositions.[192] Education officers facilitate the committees' work with up-to-date information, and their activities include allowing openly HIV-positive people from the outside community to talk to prisoners, using videos and medical literature, using professional scriptwriters to develop educational resource materials, and organizing poster competitions. The education officers also liaise with prison staff and authorities and prisoners.

In the United States, the National Commission on AIDS examined existing educational programs, concluding that they "vary enormously from jurisdiction to jurisdiction."[193] Among the *Recommendations for AIDS Prevention Programs in Correctional Settings* endorsed by the Commission are the following: (1) All inmates should participate in a mandatory AIDS information and educational session upon entry into the system. (2) Inmates should have the opportunity to participate in ongoing groups that provide information and support about risk reduction. (3) Peer educators can play an important role in prison AIDS prevention programs. (4) Prevention programs need to be closely linked to health and social services for inmates with HIV/AIDS. (5) Prisoners should be included in planning and implementing AIDS-prevention programs. (6) Correctional systems, prison health services, AIDS organizations, prisoners' rights groups and public health professionals need to work together to create effective AIDS-prevention programs in correctional settings.[194] The *Recommendations* conclude with the statement that

> AIDS prevention programs remain the single most effective strategy for slowing the spread of HIV infection. Inmates, like others in society, have the right to be protected from life-threatening illnesses. For legal, moral and public health reasons, correctional and health officials should develop effective and comprehensive AIDS prevention programs in correctional settings.[195]

The National Prison Project on Care and Treatment of HIV-infected Prisoners also acknowledged that "[a] comprehensive and quality education program is one of the most successful tools for controlling HIV infection in prison."[196] In particular, the Project recommended that all prisoners, on intake, should be mandated to attend an AIDS educational session that includes a live presentation by an AIDS educator and the dissemination of simply written educational

materials. These programs should be conducted by outside organizations such as a public health department or local AIDS service agencies. Because prisoners are generally skeptical of information received from correctional staff, the Project recommended periodic follow-up educational sessions for prisoners who wish to receive further information, and the setting up of support groups for HIV-infected prisoners, those with a history of IV drug use, the "worried well" and others. Finally, the training and utilization of prisoners as AIDS educators was seen as essential to the success of any AIDS educational program.[197]

The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* also emphasize the importance of education and information for inmates about HIV/AIDS. They contain the following provisions:

14. Prisoners and staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release. The information should be coordinated and consistent with that disseminated in the general community. Information intended for the general public (through posters, leaflets, and the mass media) should also be available to prisoners. All written materials distributed to prisoners should be appropriate for the educational level in the prison population; information should be made available in a language and form that prisoners can understand, and presented in an attractive and clear format.

16. Prisoners should receive HIV/AIDS education on entry, during their prison term, and in pre-release programmes. All prisoners should have an opportunity to discuss the related information with qualified people. Face-to-face communication, both in groups and on an individual basis, is an important element in education and information.

17. Consultation with, and participation of, inmates and staff in the development of educational materials should be encouraged.

18. In view of the importance of peer education, both prison staff and prisoners themselves should be involved in disseminating information.[198]

Respondents to ECAP's *Working Paper* generally agreed with the Committee's conclusions regarding educational programs for inmates about HIV/AIDS. Some respondents felt that ECAP should have emphasized that such programs need to take into account the needs of people with disabilities, and with different cultural identities and linguistic backgrounds. One respondent, Dr. Rothon, who chairs the Federal/Provincial Corrections Health Education Steering Committee of British Columbia, felt that the *Working Paper* had not devoted sufficient attention to funding and development of in-house resources for AIDS education and counselling. She pointed out that the needs of prisoners and staff in correctional facilities are often very specific, and claimed that the British Columbia Corrections Branch has not had good experiences with many external, community-based AIDS or prisoner organizations. According to her, they have often been "ill-informed and ill-prepared to deliver accurate, unbiased and up-to-date information and have resembled prisoner and patient advocacy groups more than teaching organizations." She concluded by saying:

> We support strong in-house education program[s], staffed by competent health educators, contracted jointly to Federal and Provincial Corrections. This joint effort assures uniformity and consistency of information, consistently delivered throughout all correctional facilities. To that end, the Federal/Provincial Corrections Health Education Steering Committee of British Columbia ... has submitted a funding proposal for just such an initiative in British Columbia. ... We believe that programs of this nature, supplemented with selected, proven

> community resources, are the most effective means of educating prisoners and correctional staff on AIDS, associated risk factors and available resources.[199,[30]]

Another respondent, however, argued that relying on internal sources of education was "not necessarily an ideal choice when HIV/AIDS education should be directed at prisoners with recognized literacy and language needs." She continued by saying that "[c]orrectional staff are not educators," and that "special external educators are likely better trained to address prisoners' needs and gain the trust of the inmate population."[200]

ECAP'S ASSESSMENT

> In today's society we are constantly being bombarded with media hype and other people's unfounded fears and insecurities that we are actually *less* educated than we think about the issues and how HIV/AIDS is spread.[201]

ECAP believes that education of inmates about HIV/AIDS is the most important effort that can be made to promote and protect their health, particularly since prisoners are often "the people previously missed by traditional and mainstream education and prevention ... [b]ecause they are usually out of school and may have low levels of literacy."[202] Prisons present extraordinary opportunities and challenges for HIV/AIDS prevention efforts:

> On the one hand, no other institution in this society has a higher concentration of people at substantial risk of HIV infection. Moreover, the population in prisons and jails is unlikely to have been reached by other AIDS education programs. On the other hand, formidable obstacles impede effective programs in the correctional system. These include an authoritarian atmosphere, preoccupation with security, inmates' mistrust of public health professionals, violence, discrimination and a high turn over of inmates.[203]

ECAP sometimes heard from inmates that they had received enough and did not need or want more education about HIV/AIDS. Other inmates told ECAP that they had never received education about HIV/AIDS in prison or that it was limited to making pamphlets on HIV/AIDS available to them and to regular screening of an HIV/AIDS video on the internal TV channel. Criticism that the educational and information programs provided to inmates are ineffective was also often voiced. It quickly became obvious to ECAP that the quantity and, in particular, the quality of education on HIV/AIDS varies greatly among institutions, from live education sessions with the participation of outside community groups to the provision of printed and video materials. The results of the studies undertaken by the John Howard Society of Metropolitan Toronto revealed that, although inmates may have a relatively high level of knowledge and awareness about HIV/AIDS, they also have many misconceptions and unfounded fears. Further, most inmates indicated that they felt it would be useful to have more or better educational programs on HIV/AIDS than what was currently available to them.[31]

Although ECAP commends CSC for making available and continually upgrading educational materials on HIV/AIDS for inmates, it strongly believes that educational efforts should shift from purely passive to more active and participatory forms of education. There are many reasons why current educational efforts are often perceived as being ineffective. Among these are that information may not "engage" inmates, in particular when there is non-inmate authorship and content, that it does not meet the literacy requirements of inmates, and that input from external groups into, and peer reinforcement of, educational efforts are lacking.

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[30] In October 1993 this proposal was accepted and a full-time health educator for federal and provincial correctional institutions in British Columbia was appointed. A part-time educator will be appointed in the near future.

[31] For more details, see *HIV/AIDS in Prisons: Background Materials*, Appendix 6: Results of the Inmate Questionnaire.

To ensure that all inmates receive basic information about HIV/AIDS, every inmate should be given informational materials on HIV/AIDS, such as brochures or the booklet *Get the Facts*, published by the John Howard Society, at the time of admission.[32] These materials should realistically address the risks from sexual activity and drug use in the institutions.

However, making written information available is not enough, because some inmates may not read pamphlets or brochures. Also, "live education" is often more effective in transmitting knowledge than purely passive forms of education. Therefore, every inmate should participate in educational sessions about HIV/AIDS as part of the reception program.

Thereafter, educational sessions about HIV/AIDS should be available to inmates on a regular basis. These sessions should encourage the participation of the individual inmate and include role-plays and other interactive forms of communication. Whenever possible, these sessions should be delivered or supplemented by external, community-based organizations, which should be funded to develop and carry out such programs, or by peers who have developed expertise in doing so. Responses to ECAP's questionnaire clearly supported this approach.

Further, inmates should have the opportunity and be encouraged to participate in ongoing groups that provide themselves with information and support about risk reduction. A single intervention, even if repeated on a regular basis, is unlikely to lead to significant changes in risk behaviour. Inmates need an opportunity to learn preventive skills, explore feelings, and raise questions.[204] Such programs would best be developed by peers and could be integrated into a variety of existing programs.

The need for and effectiveness of peer-led educational efforts has also been widely recognized. In some prisons peer education is already a major component of efforts to prevent the spread of HIV infection. ECAP believes that peer educators can play a vital role in educating other inmates.

Generally, ECAP believes that peer education and educational sessions delivered by external organizations will be better received than education by CSC staff. Although development of good in-house educational programs is essential, any such program should be supplemented by input from external groups and peer-led educational efforts, and should be developed in conjunction with external groups and input from prisoners and staff. ECAP was encouraged to see that CSC and the former Minister of National Health and Welfare, the Hon. Benoît Bouchard, have both expressed support for education carried out by external organizations or by peers. In this context, CSC is to be congratulated for its promising initiative of designating an inmate of Kingston Penitentiary as a paid health counsellor. This initiative should be extended to other institutions.

Regarding the question of whether participation in educational sessions about HIV/AIDS should be mandatory, ECAP received mixed answers. Some inmates and groups like the Prisoners with AIDS/HIV Support Action Network (PASAN) expressed the fear that inmates would not participate if participation was voluntary. It has also been argued that mandatory sessions would reduce the stigmatization that can occur if HIV/AIDS educational programs are voluntary. Others said that inmates would be "turned off" and unwilling to attend if participation was mandatory. Most inmate committees and individual prisoners who responded to ECAP's questionnaire indicated that attendance in educational programs should be voluntary.

ECAP believes that participation in the educational sessions given at entry into the prison system should be compulsory. All inmates should receive "live" information on how to protect themselves

[32] An evaluation of *Get the Facts* with inmates at the Toronto Jail revealed that inmates voiced overwhelming support and appreciation for the booklet. See, Toepell A.R. Evaluation of *Get the Facts* with Inmates at the Toronto Jail. John Howard Society of Metropolitan Toronto, 1993 at 9.

from contracting infectious diseases, in particular HIV/AIDS, at entry into the prison system. Participation in any other educational sessions should be voluntary, but should be strongly encouraged in order to attract a large but interested audience. This could include providing incentives or payment for attending or participating in such activities. One inmate suggested that "outside seminar leaders" should be brought in to talk to the inmates at their workplace:

> If outside seminar leaders were brought in and went to talk to the inmates where they work an easier atmosphere would be developed. Inmates would be in a group they are already relatively comfortable with. The groups would be relatively small and would encourage interaction in a familiar environment. Meeting at the inmates' place of employment would get away from the idea of mandatory attendance. This method would also reach the staff supervisors who are there. Small – 1 or 2 person – shops or jobs could be amalgamated in a related area to keep the informality.[205]

RECOMMENDATIONS

5.1 ECAP considers that education about HIV infection and AIDS is the most important effort to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in federal correctional institutions. In order to improve existing educational efforts, ECAP recommends the following:

(1) All inmates should receive written information about HIV infection and AIDS. This could be in the form of pamphlets or of a booklet such as *Get the Facts*, published by the John Howard Society.

(2) As part of the reception program, every inmate should be offered educational sessions about HIV infection and AIDS.

(3) Educational sessions about HIV infection and AIDS should be available to inmates on a regular basis. External, community-based AIDS, health or prisoner organizations should be encouraged to deliver or supplement these sessions.

(4) CSC in collaboration with Health Canada and others should fund such organizations to provide this education.

(5) Inmates should be encouraged to develop and should be assisted in delivering their own peer education, counselling and support programs.

(6) CSC in collaboration with Health Canada and others should fund such efforts.

(7) In each institution, CSC should create or designate one or more inmate job positions as peer health counsellors, and provide for appropriate training, support and evaluation.

(8) Participation in educational sessions about HIV infection and AIDS at entry into the prison system should be mandatory for all inmates. Participation in subsequent educational sessions should be voluntary but strongly encouraged.

(9) Education should take into account and respond to the needs of prisoners with disabilities, from different cultural and linguistic backgrounds, and with different levels of literacy.

5.2 EDUCATION ABOUT DRUG USE[33]

CURRENT SITUATION

CSC has made a strong commitment to providing programs and services for drug users. This is seen as "part of CSC's effort to successfully reintegrate offenders into the community, especially since close to 70 per cent of offenders exhibit substance abuse problems to some degree."[206] Although CSC acknowledges that it "cannot claim to have all the answers, we [CSC] feel we are heading in the right direction."[207] In the past, substance abuse programming within CSC was very fragmented, and it was felt that a process was needed "to bring everything together in a focused way and to co-ordinate the efforts of different departments."[208] This led to the creation in August 1989 of the Task Force on the Reduction of Substance Abuse. The Task Force subsequently developed a framework within which CSC could plan and implement programs, services and policies to reduce alcohol and drug-related problems among offenders. The 53 recommendations contained in the Task Force's report include several that deal with education for inmates about drug use.

Recommendations 15 through 17 deal with the development and delivery of a Substance Abuse Induction Module targeted to all newly admitted inmates. The goal is "to provide education and information on CSC policies and procedures in order to influence offender attitudes and intentions against abusing drugs and alcohol, and encourage participation in programs which address individual needs."[209] The Task Force suggested that, upon completion of the module, offenders should be able to: (1) describe aspects in a person's life that are negatively affected by use of alcohol or other drugs; (2) identify CSC policies and procedures that address the use of alcohol and other drugs; (3) discuss the links between drug use and criminality, violence in the institution, and re-integration into society; (4) identify personal/social consequences of using/not using alcohol and other drugs in prison; and (5) describe program opportunities available to them, and how they will get involved.[210]

As a result of these recommendations, a half-day Drug and Alcohol Reception Induction Module has been developed for use with all offenders in reception programs. This module "is designed to encourage those individuals to think about the way alcohol and drug use, either their own or that of members of their family, has affected their lives."[211] A video is being produced as part of the module. This will "portray a realistic story of a male offender and a female offender who have recently returned to a correctional facility as a result of substance abuse."

Further, a Computerized Lifestyle Assessment Instrument (CLAI) is operational in all CSC reception sites. CLAI was originally used in the community to screen health problems and was later adapted for use with offenders. CLAI's two primary uses are to identify the nature and seriousness of drug use problems among newly-admitted offenders, and to provide statistical

[33] Many terms are commonly used to describe or define the use, misuse or abuse of drugs, of which "drug abuse" or "substance abuse" may be the most widely accepted. However, the difficulty of defining the boundaries between what constitutes drug use, misuse or abuse, as well as the controversy surrounding these terms and their boundaries, have to be recognized. In its "*Lexicon of Psychiatric and Mental Health Terms,*" WHO recognizes that the term "drug abuse," defined as "[t]he self-administration of a medicinal or pleasurable substance in a quantity or manner that impairs health or social functioning," has pejorative overtones, and advises "to restrict its use to indicate the malevolence of an individual, or of his or her behaviour." The terms "drug abuse" and "substance abuse" will therefore not be used in this Report, except when they refer to CSC programs (where the term "substance abuse" is used) or to texts of other authors who use other similar terms. Rather, the neutral term "drug use" will be used. Any drug can be used in a harmful way, impair health, cause disease or lead to chronic consumption. Harms can result if too much of a certain drug is taken, if a drug is taken regularly over a long period of time, if it is taken for the wrong reason or without following instructions, or if it is taken in combination with certain other drugs. Rather than talk about "drug abuse," it is therefore more useful to talk about "drug use" without a priori judgment about whether the behaviour concerned is or is not a "problem" or "harmful." A two-stage analysis is often necessary, i.e., "an objective and empirical description of a society's pattern and determinants of drug use, and a social process which determines what part of the total spectrum of use is to be viewed as abuse." For a more detailed discussion, see Jurgens R, Gilmore N, Somerville MA. Drugs and Drug Use. In *Drug Use and Human Rights in Europe.* Edited by J. Silvis, A. Hendriks, N. Gilmore. Report for the European Commission. Utrecht/Montreal: 1992, 7-31 at 11-12, with many references.

information about the offender population which will assist in the development of future programs.[212]

Recommendations 18 through 21 deal with the delivery of educational programs on substance abuse within CSC. Education about substance abuse is seen as "an interactive process, which provides the offender with the knowledge and awareness to critically evaluate the impact of substance abuse on his/her life."

An Alcohol, Drugs and Personal Choice Program consisting of nine three-hour educational sessions is now being implemented on a national level. The primary objective of this educational program has been described as "[making] participants aware of the costs of substance abuse, both to themselves as individuals and to society." The program is intended to influence participants' attitudes toward substance abuse and to motivate them to change their behaviour.

Implementation of a program designed to meet the needs of those offenders who require a moderate level of intervention is also underway. The Offender Substance Abuse Pre-Release Program (OSAP) consists of 26 half-day sessions and is intended "to give offenders the basic skills they need to cope with situations involving drugs and alcohol." OSAP is based on the "social learning model of addiction" and contains eight main components: alcohol and drug education, self-management skills, social skills, job-skills refresher, leisure and lifestyle, pre-release planning, relapse prevention and management, and one-on-one counselling sessions.

The Reception Module and these two programs are part of CSC's effort "to explore new ways to provide the most effective programming for offenders." A data-collection system has recently been implemented to provide a summary of substance-abuse programming within CSC. Staff will report four times a year for each substance-abuse program available to offenders in the community and in the institutions. The data collected will assist CSC "in mapping future directions."[213]

THE DEBATE

Most of the issues that arise in any debate about education on drug use in prisons have already been discussed in section 5.1 of this Report, which deals with education about HIV/AIDS. It is generally agreed that: (1) educational materials, whether on HIV/AIDS or on drug use, are likely to correspond better to the reality and needs of the populations targeted, and therefore be more credible and effective, if the populations to which they are targeted participate in their development; (2) that outside community-based or health organizations should deliver, or have input into, educational sessions; and (3) that peer education should also be a priority. This is reflected in the recommendations that have been made with regard to education on drug use in prisons. For example, PASAN recommended that community-based workers should educate prisoners about drug use as a health issue.[214] PASAN views an educational component relating to drug use as an essential part of the health-care model it proposes for dealing with drug use in prisons. It points out that education is better received by inmates when provided through outside sources and through an inmate peer-support program, and suggests that educational programs be developed by "an appropriate pool of community resources." Similarly, Diane Riley in her submission to ECAP suggests that drug education programs should be run by community-based organizations brought into the prisons and that peer education programs should be encouraged.[215]

One inmate commented that CSC's substance-abuse programs were "a general waste of time – dispensing of outdated or factually false information is the staple of the institutional programs CSC funds." He pointed out that most of these programs "are now taught by CSC personnel who have no personal experience with what they are talking about. Their information largely comes from books written by people who got their information from books."

With regard to education on drug use, the World Health Organization's *Guidelines on HIV Infection*

and AIDS in Prisons contain the following provisions:

> 22. As part of overall general HIV education programmes, prisoners should be informed of the dangers of drug use. The risks of sharing injecting equipment, compared with less dangerous methods of drug-taking, should be emphasized and explained. Drug-dependent prisoners should be encouraged to enrol in drug treatment programmes while in prison, with adequate protection of their confidentiality. Such programmes should include information on the treatment of drug dependency, and on the risks associated with different methods of drug use.
>
> 26. Orally ingested or inhaled psychoactive substances, such as cocaine, solvents and alcohol, some of which are used to a considerable extent in different prison settings worldwide, may increase the likelihood of HIV transmission by impairing judgement and hindering the adoption of preventive measures by prisoners in circumstances where these measures would be required. Therefore, actual and potential users of psychoactive drugs should be made aware of this, as well as of other possible harmful effects and consequences of these substances in the broader context of health education.[216]

Respondents to ECAP's *Working Paper* generally agreed with the Committee's conclusions regarding educational programs for inmates about drug use. One respondent said:

> The recommendations here, if implemented, may go a long way to addressing the issue of drug use and prisoners.'[217]

An inmate who responded to the *Working Paper* emphasized that, "unless substance abuse problems are treated as an illness and efforts are made to reach the underlying issues which relate to the substance abuse or addictive personality, the CSC will continue to throw "good money after bad," and make no significant difference in drug abuse education."[218]

ECAP'S ASSESSMENT

ECAP commends CSC for its major effort to provide inmates with programs on drug use. In particular, ECAP agrees with a statement by John Eno, formerly a substance-abuse coordinator at Drumheller Institution and now co-responsible for substance-abuse programming within CSC at the national level. He stated that CSC's substance-abuse programming efforts "are now heading in the right direction" but that they "still have a long way to go."[219] ECAP was impressed by the programs available to inmates and by the fact that outside organizations are sometimes asked to supplement the information provided. However, ECAP believes that these efforts to educate inmates about drug use can be made more effective.

At entry into the prison system, every inmate should receive information about the options for education, care and treatment available in the institution to everybody who has problems related to drug use. Information should also be made available on ways to reduce the harms from drug use, in particular through the sharing of needles for injection drug use.

Outside community-based or health organizations should deliver, or have input into, educational sessions. Inmates often told ECAP that they disbelieved or were skeptical of much of the information currently provided in the course of the programs delivered by CSC personnel. Generally, ECAP was told that when community-based groups were invited to give presentations on drug use, the presentations were much better received by inmates. This is consistent with the results of the questionnaire ECAP sent to inmate committees. Most respondents indicated that educational programs should be delivered by outside health or community organizations.[34] ECAP believes that input by community groups

[34] For more details, see *HIV/AIDS in Prisons: Background Materials*, Appendix 6: Results of the Inmate Questionnaire.

into educational programs on drug use is essential. The focus of current CSC programming is on reduction of drug use rather than of the harms from drug use. While efforts to prevent or reduce drug use may be important, ECAP believes that education about how to reduce the harms from drug use is also essential. This includes education about safer injection drug use. As Heilpern and Egger have stated, "the importance of preventing the spread of the disease makes it essential that information on cleaning drug equipment must be provided."[220] Outside community groups would be particularly suited to provide inmates with such information and education. Further, in the context of education about how to reduce the harms from injection drug use, it will be important to not only provide relevant information but also to make accessible the means that will enable inmates to practice safer injection drug use.

Peer education should also be a priority. Because it has been found to be one of the most effective means of educating people about drug use, peer education should be promoted, and inmates should be assisted in developing their own educational programs.

RECOMMENDATIONS

5.2 ECAP considers that education about drug use is one of the most important efforts to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in federal correctional institutions. In order to improve existing educational efforts, ECAP recommends the following:

(1) All inmates should receive written information about issues raised by drug use. This should include information about educational programs on drug use, about treatment options available in the institution, and about ways to reduce the harms from drug use and to prevent infections, including ways to clean injection equipment.

(2) The Drug and Alcohol Reception Induction Module should be revised to include input by external, community-based organizations and by inmates.

(3) The Alcohol and Drug Education Program should be revised to include input by external, community-based organizations and by inmates.

(4) External, community-based drug-use, health or prisoner organizations should be encouraged to deliver or supplement these programs.

(5) CSC in collaboration with Canada's Drug Strategy and others should fund such organizations to provide this education.

(6) Inmates should be encouraged to develop and should be assisted in delivering their own peer education, counselling and support programs.

(7) CSC in collaboration with Canada's Drug Strategy and others should fund such efforts.

(8) Education should take into account and respond to the needs of prisoners with disabilities, from different cultural and linguistic backgrounds, and with different levels of literacy.

6. PREVENTIVE MEASURES FOR INMATES

6.1.1 CONSENSUAL SEXUAL ACTIVITY

CURRENT SITUATION

Prevalence of consensual sexual activity

There are no reliable data on the prevalence of consensual sexual activity in Canadian prisons. Nevertheless, there is no reason to presume that it does not occur or that it may not be widespread.

Measures to prevent sexual transmission

One of the most important steps toward instituting effective measures to prevent HIV transmission in correctional settings was making condoms available in federal penitentiaries as of 1 January 1992. Each penitentiary has established its own system for making them available: these range from distributing condoms to every inmate and leaving supplies of them in living units in some prisons, to restricting their distribution to prison health-care services. Dental dams are made available to female inmates. Lubricant availability varies significantly from institution to institution. In some institutions lubricants are not made available, in others they are available upon request, and in others they are given out together with condoms or made available through a lubricant dispenser on every range.[221]

THE DEBATE

Prevalence of consensual sexual activity

> Homosexual activity occurs inside prisons, as it does outside, as a consequence of preferred sexual orientation. In addition, prison life produces conditions which encourage the establishment of homosexual relationships within the institution."[222]

The prevalence of consensual sexual activity is difficult to estimate, but is presumably based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification and the extent to which conjugal visits are permitted.[223]

Regarding the prevalence of sexual activity in Canadian prisons, the Parliamentary Ad Hoc Committee on AIDS stated that "[w]e know that there is sexual activity in prison"[224] and referred to several studies on the extent of sexual activity in prisons in the United States.[225] These studies suggest that between 10 and 30 percent of inmates engage in homosexual activity. "[H]omosexual activity among male prison inmates, including situational homosexuality, is a significant, widely-recognized behaviour pattern in prisons."[226]

Measures to prevent sexual transmission

According to the latest figures from the World Health Organization's network on HIV/AIDS in prison, 23 of the 52 prison systems sampled allow condom distribution.[227] Significantly, no country that has adopted a policy of making condoms available in prisons has reversed the policy. In some countries, however, making condoms available in prisons is still opposed on the grounds that sexual activity is illegal in public and that prisons are public spaces. Among the systems that refuse to make condoms available are many in the United States, where the National

Commission on AIDS stated in 1991 that it was "distressed to find that only a handful of prison systems distribute condoms."[228]

In Canada, the National Advisory Committee on AIDS,[229] the Royal Society of Canada,[230] and the Parliamentary Ad Hoc Committee on AIDS[231] had each recommended that inmates be given confidential access to condoms long before they were made available by CSC in 1992. Since then, some of the provincial prison systems have followed the decision of the Solicitor General of Canada and have made condoms available to prisoners in provincial prisons or are considering doing so in the near future. Some provinces, however, including New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island and Saskatchewan, had, at the time of their submissions to ECAP, no plans to make condoms available.

The decision by CSC to make condoms available has been widely praised. For example, the Canadian AIDS Society stated:

> We wish to acknowledge that progress has been made on this very issue [HIV/AIDS in prisons]. We were very pleased by the Fall announcement by the Solicitor General of Canada to have condoms available in federal prisons. It is an important step and has acted as a catalyst for discussion in provincial ministries.[232]

However, in federal penitentiaries, as in other prison systems where condoms have been made available, "finding the best distribution channels and encouraging condom use remain problems, even when the principle of availability is accepted."[233]

The Ontario Regional HIV/AIDS Advisory Committee reviewed the adequacy and confidentiality of the condom distribution process and concluded that "[c]ondom dispensing should be readily available, anonymous, and not obsessed with the number of condoms per offender."[234] In particular, the Committee recommended that condoms be distributed in institutions free of charge through the health-care centre, where offenders should not have to ask for them or sign for them. They should also be available in other locations, to preserve anonymity, just as dispensers should be open receptacles, to ensure privacy. Finally, packets of lubricants should be available in the same location as the condoms.[235]

PASAN also expressed concern with the method of condom distribution and recommended that they should not only be distributed through health-care services but should be available in showers and on ranges. In particular, PASAN emphasized that condoms should be available safely and confidentially, and that dental dams and lubricants should also be easily accessible and free of charge to both men and women.[236]

The 1989 Australian National HIV/AIDS Strategy also pointed out that "condoms should be freely and anonymously available to all prisoners."[237] Similarly, the French National Commission on AIDS [TRANSLATION] "hopes that condoms will be systematically made available to inmates who want them ... and also that a kit containing toiletries (toothbrush, toothpaste, etc.) as well as condoms be provided free-of-charge to inmates upon incarceration."[238]

The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* provide that:

> 20. Clear information should be available to prisoners on the types of sexual behaviour that can lead to HIV transmission. The role of condoms in preventing HIV transmission should also be explained. Since penetrative intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention. They should be made available prior to any form of leave or release.[239]

The respondents to ECAP's *Working Paper* generally agreed with ECAP's conclusions regarding access to condoms in correctional

institutions. One respondent, an inmate in a federal correctional institution, expressed concern with the fact that in many institutions condoms are not easily accessible, and are made available only through the health-care units or the canteen. He suggested that, rather than leaving it to the individual institution to establish its own way of making condoms available, all institutions be instructed to make condoms widely and discreetly available. He also expressed concern that "health kits" would not be distributed in each institution because of cutbacks and budget reductions.[240] CSC staff from one institution suggested that a bulk order could be made to purchase such "health kits," in order to cut down the costs of implementing this measure.[241]

ECAP'S ASSESSMENT

ECAP commends the Solicitor General of Canada for his decision to make condoms available to inmates in federal penitentiaries. ECAP was constantly told by both staff and inmates that this decision has been well-accepted and has not created any documented problems in the institutions. This is consistent with the experience in other prison systems like that of New York City: years of experience have shown that condom availability has not resulted in security problems or other negative incidents.[242] It is also consistent with the results of the questionnaire ECAP sent to staff. Of 423 staff who responded to the question, has availability of condoms created any problems in your institution?, 345 (81.6 percent) responded no, while 58 (13.7 percent) responded yes, and the remaining 20 (4.7 percent) responded that they did not know.[35]

In many federal institutions condoms are easily and discreetly available to inmates. In these institutions condoms are available not only in the health-care centres but also in other locations where inmates regularly meet, or which they pass through or have access to. Inmates in some institutions have complained to ECAP that they do not have discreet access to condoms. These inmates said they were afraid to pick up condoms at the institution's health-care centre for fear of being identified as engaging in homosexual activity and of being discriminated against. In their responses to the questionnaires sent to them, many of the inmate committees and some staff also expressed a wish that condoms be made available through mechanisms or channels other than those already used in their particular institution. Water-based lubricant is essential to the correct use of condoms and to other safer sex practices, but ECAP was informed that it is not always available to inmates or that, as is the case with condoms, access to it is not always easy or discreet. This was confirmed by a recent survey of lubricant availability undertaken by CSC's Health Care Services Branch.

ECAP has considered what the optimal mechanisms for condom distribution might be. The Committee believes that inmates in every institution should be able to obtain condoms easily and discreetly and that there should be no real or perceived barriers discouraging inmates from protecting themselves and their partners when engaging in sexual activity. This should also apply to access to dental dams and water-based lubricant.

The Committee also considered whether or not condoms should be given to prisoners at entry into prison, and to prisoners leaving prison, for example in a "health kit." Such a kit would include condoms, dental dams, lubricant, educational materials, band-aids, disinfectant, acetaminophen, and relevant information about drug use and health services. ECAP favours distribution of a "health kit" to every inmate on entry into prison, and believes that provision of such a kit is important for the following reasons. It would make available to inmates the materials necessary for them to protect themselves against HIV transmission, without their having to go and ask for them or having to pick them up where they might be seen by staff or fellow inmates. This would also contribute to the destigmatization of

[35] For more details, see *HIV/AIDS in Prisons: Background Materials.* Appendix 5: Results of the Staff Questionnaire.

sexual activity in prison and encourage more open discussion about it. At the same time, inmates would be provided with basic medical supplies, and this would have the effect of emphasizing the importance of their looking after their health and well-being. Further, offering a "health kit" to inmates on exit from prison would be an acknowledgment that prison authorities not only have an obligation to prevent HIV transmission in prisons, but that they are also working to protect the community as a whole by ensuring that inmates who are released have the means to protect themselves and others from HIV transmission.

RECOMMENDATIONS

6.1.1 ECAP considers it essential that inmates have discreet and easy access to the means to prevent the sexual transmission of infectious diseases, including HIV, in federal correctional institutions.

In order to discourage unsafe sexual activities in correctional institutions and to reduce real or perceived obstacles to safer sexual practices, ECAP recommends the following:

(1) Condoms, dental dams and water-based lubricant should be available to inmates not only in the health-care centres of the institutions, but also in locations where they regularly meet, through which they pass or to which they have access.

(2) A "health kit" should be given to every inmate on entry into the institution and offered to every inmate on exit from the institution. This kit should contain condoms, dental dams, water-based lubricant, educational materials about sexually transmitted diseases, band-aids, disinfectant, acetaminophen and relevant information about drug use and health services.

(3) A "health kit" should always be available in each family visiting unit.

6.1.2 STATUS OF CONSENSUAL SEXUAL ACTIVITY

CURRENT SITUATION

Sodomy between consenting persons 21 years of age or older was decriminalized in Canada in 1969 (see *Criminal Code*, R.S.C. 1970, c. C-34, s. 158). On 1 January 1988 new sexual offences sections were brought into force. "Buggery" was eliminated as an offence and "anal intercourse" became legal between consenting persons aged 18 or over. A new system based on age and power between the partners was adopted in the defining of sexual offences (see *Criminal Code*, R.S.C. 1985, c. C-46, s. 159(2)). The age of consent for sexual acts other than anal intercourse, whether heterosexual or homosexual, was set at 14.

In federal penitentiaries, consensual sexual activity between inmates is still included in the category of institutional offences because it is considered or perceived to be an activity "that is likely to jeopardize the security of the penitentiary" under s. 40 (m)(ii) of the *Corrections and Conditional Release Act*.

THE DEBATE

People who maintain that sexual activity between inmates should remain an institutional offence often argue that prisons are not private spaces and that sexual activity undertaken in prisons

would constitute a criminal offence.[243,[36]] They also argue that removing sexual activity between inmates from the list of institutional offences would condone or even encourage homosexual activity.

Others, including some CSC personnel, have acknowledged the dichotomy between prohibiting sexual activity between inmates and making condoms available to them.[244] In particular, the Ontario Regional HIV/AIDS Advisory Committee expressed its concern that implementation of condom distribution without a review of institutional rules about offender sexual activity may constitute entrapment. The Committee recommended that each institution review its rules and regulations regarding sexual activity between offenders."[245] Similarly, PASAN recommended that consensual sex between prisoners not be an institutional offence:

> Sexual activity between inmates is a fact of prison life, a fact which CSC, with their condom distribution plan, has finally acknowledged. But consensual sex between prisoners remains prohibited. This means that when prisoners are having sex they will be less likely to have safer sex; the extra time required is time in which they may be discovered and penalized. In order to fight the transmission of HIV most effectively, there must be no penalties for consensual sex between prisoners.[246]

PASAN added that consensual sexual activity should be allowed not only because this will increase the effectiveness of HIV prevention, but also because it considers that prohibiting sexual activity between prisoners "is a violation of human rights." It continued by saying that the argument that sex must be prohibited to maintain order in the prison is unsound:

> Sexual activity continues to take place in prisons, despite being banned, and there is no loss of order and control. In fact, the need to be furtive while engaging in sexual activity is more a source of disorder than the sex itself.

Among the respondents to ECAP's *Working Paper*, many supported these arguments and ECAP's conclusion that consensual sexual activity between inmates should be removed from the category of institutional offences. One respondent, who supported ECAP's conclusion, nevertheless expressed the concern that if consensual sexual activity were to be allowed, it would be more difficult to identify non-consensual sexual activity.[247] The Deputy Warden of one federal institution felt that "to allow to lift the ban on sex between prisoners would be a step backwards" and that it was necessary to interdict sexual activity to protect inmates. He continued by saying that CSC must "reinforce intolerance to these activities [sex between consenting prisoners and drug use] while informing all of the hazards associated with these engagements."[248]

ECAP'S ASSESSMENT

It is increasingly accepted that sexual activity occurs in prisons and that it is being more and more tolerated. For example, ECAP is not aware of any disciplinary procedures having been taken during the past three years against inmates engaging in consensual sexual activity in federal correctional facilities. However, inmates have expressed fear that they may be disciplined when discovered while engaging in consensual sexual activity. The Committee is concerned that, due to the fear of being discovered, inmates may engage in consensual sexual activity furtively and not take the extra time required to engage in safer sex.

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[36] In the Supreme Court judgment of 12 August 1993 in *Weatherall* v. *Canada (Attorney General)* (File No. 22633), the Court held that a "substantially reduced level of privacy is present in prison – a prison cell is expected to be exposed and to require observation – and a prisoner thus cannot hold a reasonable expectation of privacy with respect to these practices [the frisk search, the "count" (regular scheduled cell patrols), and the "wind" (unannounced patrols conducted at random times every hour)]." The Court concluded that the rights of male inmates under the *Charter of Rights and Freedoms* were not violated when female correctional officers frisk them or patrol their ranges, even though male correctional officers do not conduct frisks on female inmates.

One respondent to ECAP's *Working Paper*, an inmate in a federal institution, replied to the argument that prisons are public spaces and that therefore sexual activity must be prohibited by stating that the argument "seems to ignore that prisoners masturbate, urinate, defecate, and shower in these "public" places." See, Response to ECAP's *Working Paper* by Roy Glaremin, dated 16 July 1993.

Therefore – and in the interest of discouraging unsafe sexual activity – ECAP believes that consensual sexual activity should not be considered an activity that would jeopardize the security of the penitentiary, and that it should be removed from the category of institutional offences. This should not be seen as encouraging sexual activity, but rather as discouraging unsafe behaviour. Further, ECAP believes that it would be consistent with, and in fact mandated by, the general principles guiding CSC, according to which the Service shall "use the least restrictive measures consistent with the protection of the public, staff members and offenders"; and offenders shall "retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence" (ss. 4(d) and (e) of the *Corrections and Conditional Release Act*).

It is important to make a clear distinction between consensual and non-consensual sexual activity. While the latter cannot be tolerated and may jeopardize the security of the institution, the former may only indirectly cause "problems" because of potential negative or intolerant reactions of fellow inmates, staff or the public toward people engaging in sexual activity. However, this would be more a result of the prejudices of fellow inmates, staff or the public than of the sexual activity in itself, and should therefore be dealt with through more open discussion of sexuality.

Further, the argument that prisons are considered public spaces and that sexual activity in them would constitute a criminal offence does not seem to withstand scrutiny. CSC has been allowing private family visits for years, and for this purpose family visiting units have tacitly been considered "private" spaces. The same could be done with cells. Further, the recent Supreme Court judgment saying that "a substantially reduced level of privacy is present in prison" and that "a prison cell is expected to be exposed and to require observation"[249] does not require interdiction of consensual sexual activity in cells, or of other private behaviours of inmates.

Generally, ECAP believes that the health of the inmates and, in particular, efforts to protect them from HIV transmission, should be the overriding concern in any discussion about consensual sexual activity in prisons.

RECOMMENDATIONS

6.1.2 ECAP recommends that, in order to discourage unsafe sexual activity in federal correctional institutions, consensual sexual activity between inmates not be considered an activity that is likely to jeopardize the security of the institution, and be removed from the category of institutional offences.

6.2 NON-CONSENSUAL SEXUAL ACTIVITY

CURRENT SITUATION

Prevalence of non-consensual sexual activity

There are no reliable data on the prevalence of non-consensual sexual activity in Canadian prisons. Nevertheless, there is reason to presume that it does occur.

Dealing with non-consensual sexual activity

CSC has adopted a policy of sending predators, not their victims, into protective custody, and has taken numerous other steps to prevent sexual aggression in institutions. At the time of writing, guidelines for staff and inmates on sexual assault in the correctional environment were being developed. The objective of the guidelines for staff is to "help personnel to identify and meet the Correctional Service's responsibilities in providing services to sexual assault victims and, in so doing, reduce possible civil liability."[250] The guidelines provide a definition of "sexual assault," describe

available options and consequences for the victim of an assault, suggest criteria for the identification of inmates who may be vulnerable to sexual assault and ways to provide assistance to suspected victims. They also contain procedures for intervention and investigation of recent assaults, including for evidence collection and a preliminary medical and psychological assessment. According to the guidelines, follow-up will be provided through the case management officer, and measures will be taken to ensure continuation of services once the victim is released from a correctional institution. The guidelines for inmates are intended to help inmates prevent sexual victimization, identify resources available to them in case they need help, and "recognize the choices ... [inmates] will have to make in the event of being sexually assaulted."[251]

THE DEBATE

Prevalence of non-consensual sexual activity

It has been said that "it is nearly impossible to get accurate data on the number of violent sexual encounters that happen within gaol systems."[252] Non-consensual sexual activity, including so-called "quasi-consensual" sexual activity (for example, submission based on intimidation, or submission in return for protection or other favours),[37] has been held to be prevalent and underreported in prisons. Heilpern and Egger have stated:

> Official reports seriously underestimate the extent of sexual assault. One US self report study found that 0.6% of prison inmates were forced to perform undesired sexual acts during incarceration. Another US study found that 28% of inmates had been victims of aggressive sexual approaches. In another US research [study] the estimates of the proportion of prisoners who are subject to sexual assault varies from 1% to 2.9%.[253,38]

Dealing with non-consensual sexual activity

Hankins has suggested that in order to prevent HIV transmission associated with non-consensual activity, the prison environment must be changed.[254] In particular, she writes:

> For a start there has to be a more careful inmate classification so that more vulnerable individuals are kept together and not mixed with more aggressive individuals. More extensive supervision or surveillance, more effective prosecution of inmate rapists, basic structural changes such as lighting and restricted access to certain areas in the prison may help facilitate a safer environment for all prisoners. Some individuals, especially those who are susceptible to victimization, may have to be placed in protective custody. The prevention of rape and other non-consensual sexual activity through which HIV infection may be transmitted must be a critical element of a correctional services AIDS policy.[255]

PASAN emphasizes that non-consensual sex is unacceptable, but does not address the issue of how to prevent or reduce the incidence of non-consensual sex in prisons.[256]

Heilpern and Egger acknowledge that the extent to which HIV-prevention policies are able to adequately address the problem of non-consensual intercourse is unknown.[257] They continue by saying that, although policies such as safe-sex education, the distribution of condoms,

[37] The term "quasi-consensual" sexual activity is misleading, since any "consent" obtained through intimidation cannot be considered as consent. sexual activity is either consensual or non-consensual. Nevertheless, the term is widely used to refer to sexual activity that is non-violent but for which the "consent" has been based on intimidation or submission in return for other favours.

[38] The authors note that some of the US research has been criticized for the strong ideological bias inherent in both the methodology and the conclusions. They therefore state that caution should be exercised in interpreting these findings and that, furthermore, the distinction between consensual and quasi-consensual sexual activity is problematic because a proposition may be regarded as a threat, depending upon the circumstances.

the provision of conjugal visits, single-cell accommodation and the segregation of proven predators may reduce the risk of HIV transmission, "the complexity of male prison sexuality requires an approach which both understands and challenges the value system which creates sexual domination in the prison system." They conclude by saying that educational programs in prisons need to be broad in scope and that they must come to terms with the complexity of prison sexuality and the role it plays in the culture. This means that the relationship between sexual domination, the assertion of masculinity and power and status in the prison need to be recognized, and programs that understand and challenge this value system developed.[258]

With regard to non-consensual sexual activity, the Word Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* read as follows:

> 21. Prison authorities are responsible for combatting aggressive sexual behaviour such as rape, exploitation of vulnerable prisoners (e.g., transsexual or homosexual prisoners, or mentally disabled prisoners) and all forms of prisoner victimization by providing adequate staffing, effective surveillance, disciplinary sanctions, and education, work and leisure programmes. These measures should be applied regardless of the HIV status of the individuals concerned.[259]

Respondents to ECAP's *Working Paper* generally agreed with ECAP's conclusions regarding non-consensual sexual activity between inmates. Some respondents indicated that close supervision and protection, including single-cell accommodation, for inmates who may be vulnerable to sexual abuse should only be undertaken with the consent of the concerned inmate.

ECAP'S ASSESSMENT

ECAP was concerned that one of the ways in which infectious diseases may be spread in institutions is through non-consensual sexual activity. While the Committee commends CSC for its policy of sending predators, not their victims, into protective custody, and for having taken steps to prevent sexual aggression in its institutions, it considers that reaffirming these measures is important. Such reaffirmation should include open discussion of sexual activity in penitentiaries and education of inmates, preferably by inmates, about sexual abuse.

RECOMMENDATIONS

6.2 ECAP agrees that preventing sexual assault and other non-consensual sexual activity between inmates should continue to be a priority for CSC. ECAP therefore recommends that CSC undertake the following measures, among others, to make the prison environment safer:

(1) Continued efforts should be made to identify sexual predators and inmates who may be vulnerable to sexual abuse.

(2) Effective prosecution of inmate sexual predators, and their removal or segregation from the general inmate population, should be carried out.

(3) Close supervision and protection, including single-cell accommodation, for inmates who may be vulnerable to sexual abuse, should be made available.

(4) Education of inmates, preferably by inmates, about sexual abuse and the fact that such abuse will not be tolerated in federal correctional institutions, should be undertaken.

(5) As a long-term goal, all inmates should be provided with single-cell accommodation.

6.3 PREVENTING THE HARMS FROM INJECTION DRUG USE

CURRENT SITUATION

Prevalence of injection drug use

There are no reliable data on the prevalence of injection or other drug use in Canadian prisons. The only available data are on the prevalence of drug use by prisoners prior to incarceration. A Computerized Lifestyle Screening Instrument developed by the Ministry of the Solicitor General and CSC in 1988 is being used to obtain information about the extent and nature of offenders' drug and alcohol use. Of 371 inmates tested in 1989-90, more than ten percent admitted using drugs every day in the six months prior to incarceration, 17 percent had regular drinking binges and 64 percent said they had consumed alcohol or other drugs on the day of their crime.[260] Further, 53.7 percent of all federal inmates were classified as having a serious substance abuse problem.[261]

Reducing the harms from injection drug use

MEASURES TO REDUCE DRUG USE

CSC has undertaken a variety of measures to reduce injection drug use in federal penitentiaries. These have been described as follows:

> Recognizing the serious contribution to institutional violence made by the presence and use of alcohol and other drugs in penitentiaries, the significant effect of continuing alcohol and drug abuse on criminal activity after release, as well as the general debilitating effect of substance abuse on individual and family life, the CSC has undertaken formal prevention, education and treatment measures in recent years. Stress has been placed on interdiction and apprehension, education and the treatment of addicted offenders – an approach continued to the present.[262,[39]]

Sections 54 through 56 of the *Corrections and Conditional Release Act*, according to which CSC may carry out urinalysis under certain circumstances specified in the *Act*, are also part of CSC's effort to prevent drug use.

AVAILABILITY OF BLEACH

Bleach is not officially available to inmates in federal penitentiaries. It is classified as contraband, and possession of it is considered to be an institutional offence. Nevertheless, some inmates may have covert access to bleach in laundries or kitchens and it may be available to other inmates as a commodity. In contrast, bleach is made available to inmates as a general cleansing agent in some provincial institutions, and in many prison systems worldwide.[40]

AVAILABILITY OF STERILE INJECTION EQUIPMENT

Injection equipment – needles and syringes in particular – is classified as contraband and possession is considered to be an institutional offence.

AVAILABILITY OF METHADONE

Treatment with methadone as a substitute for opiate use is not available in federal penitentiaries.

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[39] For a detailed description of CSC's educational programs on drug use, see supra at 51-54.

[40] For more details, see *HIV/AIDS in Prisons: Background Materials*. Appendix 1: Canadian Prison Policies Relating to HIV/AIDS; and Appendix 3: Policies of Selected Countries Relating to HIV/AIDS.

THE DEBATE

Prevalence of injection drug use

It has been said that drug use is more visible in prisons than outside and that "inside an often overflowing incarceration system where there is little treatment, drugs help contain a situation that would otherwise explode."[263] Riley has pointed out that many inmates use drugs as a part of their lifestyle, that drugs relieve tension, boredom and hopelessness, and that it should come as no surprise that they are popular among inmates.[264] Similarly, PASAN has said that inmates often turn to drug use "as a means to cope with the harsh reality of prison life."[265]

Drugs enter prisons on a regular basis, and availability of drugs in prisons has significantly increased since the early 1970s, in part due to increased visiting rights in most prisons.[266] It has been estimated that only five percent of all drugs entering Canadian prisons is apprehended by prison authorities.[267] Allegations that drug use in prisons is quietly tolerated by prison authorities were denied by a CSC spokesperson who maintained that "[l]ooking the other way is something penitentiary staff do on very few occasions."[268]

The Parliamentary Ad Hoc Committee heard evidence that up to 50 percent of inmates may use drugs.[269] According to other estimates, two-thirds of all prisoners use drugs while in prison.[270] The 1991 Task Force Report on the Reduction of Substance Abuse acknowledged that the problem of drug use in prisons, including the contribution of drugs to prison violence, is significant.[271] The Report continues by saying that consequently "a significant percentage of institutional security measures are devoted to drug detection and reducing illegal sales of drugs." Further, the Task Force reported that prison violence often occurs to obtain drugs or to settle debts related to the sale of drugs, that from 1981 to 1986, 49 people were killed in Canadian penitentiaries and that many of these crimes were a direct result of alcohol or drug use and trafficking in drugs. During 1985-86 alone, 181 major violent incidents occurred, of which 106 (58%) were believed to be related to drug use.[272]

Similarly, the CSC Contraband Control Study states that "it is commonly accepted that many offenders have significant problems with alcohol or drug abuse that relate to their criminal behaviour" and that "drugs and alcohol can be identified as the most important contraband problem."[273] The Study continues by saying that a significant number of offenders may continue to use drugs during their incarceration – which creates a heavy demand for drugs and alcohol within institutions – and that many or most of these offenders will be at high risk for re-offending if their drug use problems are not dealt with effectively.

With regard to injection drug use, a CSC spokesperson maintained that "[w]hen drugs are used ... they are mostly the non-injectable ones."[274] However, the Parliamentary Ad Hoc Committee heard evidence that "needle sharing for injection drug use is common, and that needles and other implements are also used for tattooing purposes."[275] An ex-prisoner estimated that ten percent of the inmates in the Guelph Correctional Centre share needles,[276] and a study on HIV transmission among injection drug users in Toronto found that "[o]ver eighty per cent [of the participating injection drug users] had been in jail overnight or longer since beginning to inject drugs, with twenty-five per cent of those sharing injecting equipment while in custody."[277]

While it is generally agreed that it is difficult to determine exactly how much injection drug use and needle sharing occurs in prisons, it is also agreed that, in Canada and elsewhere, injection drug use is prevalent in prisons and that the scarcity of needles often leads to needle sharing. With regard to the Canadian situation, PASAN stated:

> Despite high levels of injection drug use, the presence of syringes used to inject illegal drugs is severely limited. Only a handful of needles will circulate in a population of

> 400-600 people. Accordingly, once incarcerated, with no access to clean needles or bleach, yet ongoing access to injectable drugs, inmates using injection drugs must share needles even though they may not have shared on the outside. Needle sharing usually occurs in bathrooms, cells, and hidden areas. Home-made and unsafe sharps (needle substitutes) are fashioned out of hardened plastic and ball-point pens, often causing damage to veins, scarring, infections, and blood poisoning.[278]

In Australia, "[a]ll commentators agree that it [injection drug use] occurs and that needle sharing is almost always associated with IV [intravenous] drug use in prisons because of the lack of availability of syringes."[279] The following are some examples of estimates of the amount of drug use and needle sharing in Australian prisons:

> One of the more extreme estimates was made by Frape – 80% of prisoners were using drugs in NSW [New South Wales] prisons and needles were shared with up to 20 others at a time. Matthews reported that prisoners in one NSW prison claimed that there were only 2 syringes in the entire prison. The AIDS Task Force Prison working party reported that in Long Bay no more than 14 needles were available for more than 200 prisoners using IV drugs.[280]

In a survey of "HIV Risk-Taking Behaviour of Sydney Male Drug Injectors While in Prison," 155 of 209 respondents (74.2 percent) reported having injected drugs at least once while in prison. Of these, 100 (66.5 percent) provided data on the frequency of sharing of injection equipment in prison with 75 (75 percent) reporting sharing.[281]

In the United Kingdom, the Home Office claimed that there is a low incidence of injection drug use in prisons. However, a number of surveys found that the use and availability of injectable drugs greatly exceeded official estimates and that needles and syringes are commonly shared out of necessity.[282] One study found that injection drug use decreased in prisons among inmates who had been injection drug users on the outside. However, inmates were more likely to inject in an unsafe manner when they did inject. The study concluded that imprisonment increased the risk of contracting HIV infection.[283]

Reducing the harms from injection drug use

It is widely believed that injection drug use represents the biggest risk for transmitting HIV infection in prisons.[284] Heilpern and Egger have identified four lines of reasoning to support this view: (1) the geographic distribution of AIDS in prisons parallels the geographic distribution of AIDS cases where IV drug use is the primary risk factor; (2) research has shown that a high proportion of AIDS cases in prisons indicate IV drug use as the sole or predominant risk factor; (3) the prevalence of HIV infection in prisons mirrors the geographic distribution of IV drug users in different jurisdictions; and (4) the rates of seropositivity in prisons are closely related to the proportion of drug-dependent prisoners.[285] They concluded that "HIV infection in prisons will increase if there is an increase in the proportion of IV drug users imprisoned and if there is an increase in HIV infection amongst IV drug users in the general community."

Similarly, Tomaševski has indicated that there are extensive data on the association between injection drug use and HIV infection, particularly in relation to prisoners. AIDS was diagnosed among prisoners early in the epidemic and immediately linked to such drug use. This link was confirmed by a survey carried out for the Council of Europe, which concluded that the proportion of HIV-positive prisoners directly reflects the proportion of inmates dependent on drugs. This has been proven in most industrialized parts of the world, including Europe, North America, and Australia, and the problem is exacerbated by continuing injection drug use in prisons. Tomaševski continues by pointing out that two features of the prison population determine the magnitude of the dual problem of HIV/AIDS and drug use: the high proportion of injection drug users in the prison

population is a consequence of penalizing possession or use of drugs through imprisonment, while a large proportion of the prison population is dependent on drugs, whether inmates have been imprisoned for a drug-related offence or not.[286]

For all these reasons, reducing the harms from injection drug use is an essential part of any comprehensive effort to reduce or avoid the risk of contracting bloodborne infections in prisons. For example, the Canadian AIDS Society stated:

> The reality of the drug issue has not yet been addressed. A range of strategies need to be examined and implemented and need to include effective drug education and rehabilitation programmes and provisions of bleach and needle exchange. All of this is more complex within a prison setting. However, the difficulties must not deter us from finding solutions. We believe collaboration will bring workable solutions.[287]

MEASURES TO REDUCE DRUG USE

Implementation of effective drug education, including education about how to reduce the harms from injection drug use, has been widely recommended. Other measures to reduce drug use in correctional facilities are more controversial. In particular, there is concern that these measures may create risks or harms that outweigh the benefit being sought, namely the reduction of drug use. For example, it is feared that drug-testing programs may have a negative impact on efforts to reduce the harms from drug use. In his submission to ECAP, Oscapella pointed out that the *Corrections and Conditional Release Act* gives federal corrections and parole officials broad powers to test inmates in prisons and on their release into the community under programs such as parole. According to Oscapella, "[i]t is too early to tell if the drug-testing provisions of the *Act* will be found to violate Charter privacy rights." He continues by saying that, in theory, drug testing should reduce the amount of drug use in prisons because people should be dissuaded from using drugs through fear of disciplinary action. However, he is concerned that drug testing in prisons could in practice lead to an increased frequency of injection drug use. Because marijuana metabolites are sometimes detectable in urine for up to a month, while other drugs, such as cocaine, heroin, PCP and LSD, have much shorter windows of detection, drug use in prison may shift from marijuana to these drugs. Oscapella concludes that "[a]ny policy or law that increases the chances that inmates will inject drugs – particularly in light of the unwillingness of prisons to facilitate safe injection practices – is highly dangerous. It is difficult to think of any situation where the benefits of such a policy or law would outweigh the deadly harm of increased HIV infections."[288]

In his response to the *Working Paper*, the Executive Director of the Office of the Privacy Commissioner of Canada supports "the need to assess whether drug testing programs can lead to increased harms by encouraging inmates to switch to injecting "short window" drugs to reduce the likelihood of having their drug use detected." He adds that "if drug testing does increase the risk of HIV infection, this is one more reason for not employing this intrusive technology in prisons." A reconsideration of the use of drug testing in prisons was also asked for in the response by Diane Riley on behalf of the Canadian Centre on Substance Abuse.

AVAILABILITY OF BLEACH

Whereas providing prisoners with information and education about drug use is widely accepted, the issue of whether bleach should be made available to prisoners is controversial. This is not surprising, since "[m]easures to prevent further spread of HIV infection among injecting drug users, such as needle exchange programmes or bleach, are controversial even for people at liberty."[289]

Making bleach available to prisoners has often been opposed on the grounds that it may be perceived as condoning an illegal act that has contributed to many prisoners being incarcerated in the first place. It has also been argued that making bleach and information on how to clean

injection equipment available may encourage non-users to experiment with injection drug use, and that bleach could be used as a weapon against staff.[290] However, bleach had been available for a long time in Canadian prisons without any suggestion of it being a threat to institutional security until it became associated with the sterilization of injection equipment. Further, in some institutions it is still informally available, and there is no evidence that this has created any problems. The National Advisory Committee on AIDS stated:

> Such distribution [of bleach] has not been shown to seriously compromise security within correctional facilities, nor can it be interpreted as condoning or encouraging proscribed behaviour within the facility. Instead, such measures are essential in order to reduce the risk of HIV transmission in the facility. It is unconscionable to deny inmates access to the means necessary in order to permit them to protect themselves from HIV infection.[291]

That it is becoming increasingly difficult for prison administrators to ignore the issue of needle cleaning has been recognized in other countries. For example, at a conference on AIDS in Australia one commentator said:

> In the light of the startling increase of HIV infection in the IV drug population both inside and outside jail, this controversial issue will soon be the most central issue on the agenda. ... We are engaged in an extraordinary war which demands extraordinary solutions.[292]

Bleach is made available to inmates in many prison systems. As reported by Harding and Schaller, 16 of 52 systems surveyed late in 1991 made bleach available to prisoners, often accompanied by instructions on how to clean needles. For example, in Spain a bottle of bleach is included in the sanitary kit that inmates receive at entry into the prison system and monthly thereafter, "and more is provided whenever needed."[293] In Switzerland, "first-aid kits" containing small bottles of bleach have been given to inmates since June 1991.[294] Bleach is also available in some systems in Germany, France and Australia, in prisons in Belgium, Luxembourg and the Netherlands, and in some African and at least one Central American prison system.[295]

Making bleach available to prisoners has been widely recommended in Canada and elsewhere.[296] As early as 1988, the Royal Society of Canada recommended that "facilities for decontaminating needles be made readily available to inmates in correctional institutions."[297] Two years later, in 1990, the Parliamentary Ad Hoc Committee on AIDS urged the Solicitor General to "take immediate steps to have bleach for needle decontamination purposes ... made available on a confidential basis to inmates."[298] More recently, the Ontario Regional HIV/AIDS Advisory Committee stated that offenders at all institutions would benefit from the provision of bleach to disinfect sharp instruments used in tattooing, piercing, and injection drug use. The Committee recommended that bleach kits be made available to all offenders. The kits should contain "one plastic bottle of bleach with red lettering for the poison symbol and easy instructions; one plastic bottle of clean water with yellow lettering for the instructions; one instruction sheet with low literacy printing and pictures."[299] PASAN recommended that bleach kits should be distributed universally, "possibly during the weekly provision of supplies."[300]

With regard to making bleach available, the World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* recommend:

> 24. In countries where bleach is available to injecting drug users in the community, diluted bleach (e.g., sodium hypochlorite solution) or another effective viricidal agent, together with specific detailed instructions on cleaning injecting equipment, should be made available in prisons housing injecting drug users, or where tattooing or skinpiercing occurs....[301]

Making bleach available to inmates was opposed by some respondents to ECAP's *Working Paper.* The warden of one institution, for example,

repeated the argument that by providing bleach CSC would tacitly approve of illicit drug use. He suggested two measures to deal with the problem of drug use: greater use of restricted visits for "known drug users and drug traffickers," and "providing the very best education programs available."[302] Generally, however, ECAP's conclusions with regard to availability of bleach were widely supported by the respondents to the *Working Paper*, including some CSC staff and most inmates. This is consistent with the results of the questionnaire ECAP sent to staff in federal correctional institutions. To the question, "Should bleach be made available to prisoners?", 55.9 percent responded no, but 42.0 percent responded yes, and 1.6 percent responded that bleach was already in use, while 0.5 per cent responded that they did not know whether or not it should be made available. To the same question, 85.7 percent of inmate committees and 84.6 percent of individual inmates responded yes, while only 14.3 percent of inmate committees and 15.4 percent of individual inmates responded no.[41]

Recently, however, there has been increasing doubt about the efficacy of bleach in destroying HIV. It is also uncertain whether bleach effectively destroys hepatitis B, and the current inability to detect hepatitis C antigen makes it impossible to determine whether or not bleach effectively decontaminates this agent. The effectiveness of bleach as a biological agent has been seriously questioned. An HIV/AIDS Prevention Bulletin, jointly issued on 19 April 1993 by the [U.S.] Centers for Disease Control and Prevention (CDC), the [U.S.] Center for Substance Abuse Treatment (CSAT), and the [U.S.] National Institute on Drug Abuse (NIDA), stated the following:

> Based on recent research, bleach disinfection should be considered as a method to reduce the risk of HIV infection from re-using or sharing needles and syringes (and other injection equipment) **when no other safer options are available** [emphasis in the original]. Sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and syringes.[303]

The Bulletin reviews the findings of a workshop at Johns Hopkins University, Baltimore, Maryland, that analyzed current practices and research on the use of bleach to disinfect drug injection equipment. The following are some of the findings: (1) Several papers in the 1980s showed that bleach inactivated HIV *in vitro*.[304] Consequently, bleach became "the standard for use in needle hygiene programs, and small bottles of bleach were distributed to intravenous drug users (IDUs) by outreach workers throughout the country, providing an important contact with out-of-treatment drug users. Distribution of bleach is an important element of outreach to IDUs; that outreach provides IDUs with AIDS prevention education and recruitment into drug abuse treatment." (2) Recent data raise questions about the efficacy of bleach cleaning. Bleach was found to be more effective than most other readily available solutions, such as alcohol and hydrogen peroxide, but was not as effective against HIV in blood as it was against cell-free HIV and HIV in cell culture.[305] (3) Studies of HIV seroconversion rates among a cohort of injection drug users in Baltimore compared those who reported using disinfectants all the time with those who reported never using disinfectants to clean needles and syringes. No significant difference of seroconversion was found between disinfectant users and non-users.[306] (4) A study undertaken at NIDA found that "a 10 percent dilution of household bleach (0.5 percent sodium hypochlorite) was not effective in removing blood from syringes using a 6-second rinse with bleach, followed by two 6-second rinses with water." (5) Full-strength household bleach (5.25 percent sodium hypochlorite) effectively inactivated pelleted HIV at exposures of 30 seconds or more, whereas ten-percent bleach was effective only after exposures of two hours.[307] (6) A study of videotapes of drug-users re-enacting the last time they injected drugs found that more than 80 percent of 161 subjects used bleach for less than

[41] For more details, see *HIV/AIDS in Prisons: Background Materials*. Appendix 5: Results of the Staff Questionnaire, and Appendix 6: Results of the Inmate Questionnaire.

30 seconds when cleaning syringes, although they reported cleaning for longer periods of time.[308]

The implications of these findings were summarized as follows:

> These research findings indicate that we must strengthen our efforts to help IDUs stop using and injecting drugs. Treatment for drug use (e.g., methadone treatment for opiate use) is very important in helping drug users stop or decrease drug use and drug injection. Those who continue to inject drugs must be encouraged to always use sterile injection equipment and warned to never re-use or share needles, syringes, and other injection equipment. Disinfecting previously used needles and syringes with bleach (or other chemicals) can reduce the risk of HIV transmission but **is not as safe as always using a sterile needle or syringe** [emphasis in the original]. Care should be given also not to re-use or share cotton balls, cookers, rinse/wash water, and other drug preparation and injection equipment because they may be contaminated with blood. ...
>
> Cleaning injection equipment with disinfectants, such as bleach, does not guarantee that HIV is inactivated. Disinfectants do not sterilize injection equipment. However, consistent and thorough cleaning of injection equipment with disinfectants such as bleach should **reduce** transmission of HIV if equipment is shared.[309]

Because of these findings, a number of respondents to ECAP's *Working Paper* criticized the Committee's reliance on bleach as a way to reduce exposure to HIV and other infections, and concluded that making bleach available must be regarded as an insufficient intervention.

AVAILABILITY OF STERILE INJECTION EQUIPMENT

Although making bleach available to prisoners is increasingly being accepted as necessary to prevent transmission of HIV and other infectious agents in correctional institutions and has been implemented in some prisons systems, there is strong resistance from prison authorities against making sterile drug-injection equipment available. Worldwide, no prison system has authorized the distribution or exchange of sterile injection equipment.[310] However, a syringe exchange program was in operation during 1992 in one prison in New South Wales in Australia, albeit illegally.[311] A pilot project that includes the distribution of syringes will start in 1994 in one institution in the Canton of Berne in Switzerland.[312]

In Canada, in 1991, the Minister of National Health and Welfare suggested that sterile needles or bleach to clean needles be made available to inmates in federal penitentiaries. However, at the time, the Solicitor General of Canada rejected this suggestion.

Outside prisons, needle exchanges have been established in many countries. In Canada, the first official needle exchange program began in Vancouver in January 1989, although exchanges had already opened unofficially in Toronto in 1987.[313] In June 1989 the federal government announced a special initiative to cost-share with provinces to support two-year pilot programs that could include needle exchange. Five provinces (British Columbia, Alberta, Manitoba, Ontario and Quebec) participated in this initiative to support pilot projects in 12 communities. Final results from evaluation research that was federally funded in association with the pilot projects were scheduled for release in late 1993. Initial findings demonstrate that pilot programs "have accessed thousands of drug users (approximately 4,000 contacts per month in both Vancouver and Montreal, over 400 clients per month in Toronto), have not led to increased drug use, and have linked many clients to other health and social services for the first time."[314] Well over one million needles/syringes have been exchanged through these programs. Federal funding of these pilot projects ended on 31 March 1993. Provinces have begun to fund needle exchanges as ongoing services and have greatly increased the number of sites. As of August 1993, Health Canada knew of 28 outreach programs that include needle

exchange. Eleven additional sites were under development and expected to open in 1993. The following is a list of sites of needle exchanges in Canada and of the dates on which they started:[315]

British Columbia: Vancouver (January 1989), Victoria (August 1989), Kelowna (May 1991), Prince George (August 1991), Nanaimo (November 1991), Quesnel (November 1991), Williams Lake (November 1991), Surrey (December 1992); six more programs were under development in 1993.

Alberta: Edmonton (August 1990), Calgary (Febraury 1990).

Saskatchewan: Regina (August 1992), Saskatoon (February 1993).

Manitoba: Winnipeg (October 1990).

Ontario: Toronto (June 1989), Ottawa (November 1990), Hamilton (January 1992), Kingston (November 1991), London (May 1992), Sudbury (May 1992), Etobicoke (May 1992), Windsor (July 1992), Niagara (October 1992).

Quebec: Montreal (July 1989), Montérégie (May 1990), Quebec City (March 1991), Victoriaville (June 1991), Chicoutimi (March 1992); five more programs were under development in 1993.

Nova Scotia: Halifax (May 1992).

A recent study of the impact of needle exchange programs in the United States and internationally reported that at least 37 active needle exchange programs existed in the United States on 1 September 1993; that needle exchange programs have made significant numbers of referrals to drug treatment programs and other health services; that available data provide no evidence that needle exchange programs increase drug use by exchange program clients or change overall community levels of non-injection or injection drug use; and that the majority of studies demonstrate decreased rates of unsafe injecting practices among exchange program clients.[316]

Providing sterile needles in prisons is often rejected because it would appear, "in an environment designed to uphold the law, to condone illegal drug use: a contradiction in terms."[317] There is also concern for the safety and security of fellow prisoners and staff because it is feared that needles could be used as weapons. Wayne Crawford, Executive Secretary-Treasurer of the Union of Solicitor General Employees, said:

> A needle is a weapon. I'd hate to even think about some prisoner coming up and stabbing me, or injecting me, with his blood if it's infected. ... Whether it [the needle] is rusty or new hardly matters. The whole idea is ridiculous. It would be the same as giving bank robbers normal bullets so they won't use dum-dums. People talking about this aren't in the real world.[318]

On the other side, prisoners'-rights activists have rejected the contention that clean needles pose a security risk, saying that "a prisoner wishing to use violence against a guard or another prisoner will likely utilize other already available methods, such as pencils, pens, razors, utensils, toothbrushes, etc."[319] Making sterile injection equipment available "would probably reduce the risk by eliminating dangerous, handmade syringes that have to be hidden within the prison."[320] Furthermore, "[i]f the issuing of needles was more open and protected, there would be less concern about violence and security."[321]

In Canada and internationally, making sterile drug injection equipment available in prisons has been recommended by many individuals, groups and organizations. For example, the Canadian Association of Elizabeth Fry Societies passed a resolution at its 1991 annual general meeting supporting "free needle exchange ... inside and outside the criminal justice system."[322] Prisoners with AIDS/HIV Support Action Network (PASAN) recommended that "[a] confidential needle exchange program should be implemented in prisons.[323] It suggested that needle exchange programs "should be modelled after existing outside exchange programs while simultaneously protecting prisoners from harassment from prison

staff and fellow prisoners."[324] According to PASAN, needles should be exchanged through the health service in a confidential one-for-one manner and prisoners should not be accountable to non-medical staff when obtaining needles. At the same time, the provision of a needle exchange machine in prisons was rejected because such machines "can be faulty and are easily vandalized" and because using them "poses problems for prisoners who wish to maintain their confidentiality." PASAN further suggested that "[a] public relations campaign should be initiated to combat anticipated resistance by staff or the public to a needle exchange program,"[325] and stated:

> Needle exchange programs on the "outside" are becoming more common. Experience has shown us that the few opponents they encounter in the community can be overcome through consultation and education. Harm reduction is the framework in which we promote needle exchanges to the outside community. A similar strategy should be pursued in supporting a prison exchange program.
>
> Information regarding drug use in the prisons and the health risks it involves should be made public. The success of needle exchanges in halting the transmission of HIV should also be conveyed. It should be noted that keeping a prisoner free of HIV and AIDS is a massive cost saving.[326]

PASAN claimed that "bleach provision to prisoners (in isolation from other programs around injection drug use, such as needle exchange) is not highly successful because prisoners who are injecting drugs usually feel the time and activity it takes to clean a syringe or home-made sharp could be time in which guards would detect the activity."[327] There is therefore concern that inmates would not take the extra time to clean their injection equipment and would thus continue to share dirty needles.

Others do not advocate outright implementation of needle exchanges in prisons, but suggest that the feasibility of making sterile needles available in prisons should be studied. For example, Hankins recommended that "[i]n order to further reduce HIV transmission ... the feasibility should be explored of providing inmates with confidential access to clean needles and syringes through a one-for-one needle exchange intended to reduce HIV transmission while not prompting drug use."[328] Similarly, members of the Ontario Regional HIV/AIDS Advisory Committee recommended that, given the effectiveness of needle exchanges in reducing the spread of HIV infection among drug users, "[a] proposal for a needle exchange program shall be examined in the context of the institutional setting,"[329] expressing their belief that needle sharing is an important means of HIV transmission within the institutional setting. In particular, they emphasized that needle sharing between injection drug users is a very efficient mode of transmission of HIV, that worldwide studies have shown that HIV infection in this population can increase from two percent to 40 to 60 percent within three years, and that evaluation of needle exchange programs outside prisons has shown that they are an effective means of preventing transmission of HIV and hepatitis B among drug users and have not encouraged or increased drug use among non-users.[330] At the same time, the Committee acknowledged that there was concern that advocating a needle exchange program within the institutional setting may be interpreted as condoning drug use, that needles may be used as weapons, and that there was a risk of institutional liability if an offender experiences adverse effects from the use of a needle supplied by the institution.

The Council of Europe has invited States "to allow, in the last resort, clean, one-way syringes and clean needles being made available to intravenous drug abusers in prison."[331] The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* recommend:

> 24. ... In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during

> detention and on release to prisoners who request this.[332]

In their responses to ECAP's *Working Paper*, some respondents, particularly CSC staff, indicated their clear opposition to making needles available to inmates. This is consistent with the results of the questionnaire ECAP sent to CSC staff. To the question, "Should a needle exchange program be available to prisoners?", 81.9 percent responded no, 0.9 percent responded that they did not know, and only 17.2 percent responded yes.[42] In contrast, many respondents, including the National Advisory Committee on AIDS, the Canadian AIDS Society, PASAN and international experts in the area of AIDS and drug use, have asked the Committee to reconsider its conclusion on access to sterile injection equipment and to issue a recommendation urging immediate action on this issue. They have argued that, given the current concerns regarding the efficacy of bleach as a means of destroying HIV and hepatitis, making sterile needles and syringes available to inmates needs to be an immediate priority. The Kingston AIDS Project suggested that "[o]ne reason why making clean needles and syringes available to inmates is not implementable at this time is that ECAP is not calling for it," and that "ECAP should be recommending the development of appropriate models for prison needle exchange in order to adequately address that risk of prison HIV transmission [the risk from sharing unclean equipment during injection drug use], in the face of knowing, and despite knowing, that such a recommendation will be controversial."[333] Concern was voiced that further research into introducing needles would delay their introduction, and it was suggested that, rather than concluding that studies should be undertaken, ECAP should "call for studies coupled with implementation within six months," since "[s]tudies alone will not save lives."[334] As stated by the Canadian AIDS Society, "[i]mmediate work to make access [to clean needles] a reality must be undertaken."[335] Another respondent emphasized that "[m]ost parties with any interest in the subject concur that the principal risk of HIV transmission in Canadian Federal Prisons is the sharing of dirty needles during injection drug use," and that, accordingly, ECAP's primary concern should be to find ways to reduce the use of unclean needles in the institutions.[336]

It has also been argued that the mechanisms of needle exchanges will differ significantly from institution to institution depending on the security level and the physical layout of the particular institution, and that models for needle exchange could be developed at an institutional level by combined committees of inmates and CSC staff members. Finally, it has been suggested that CSC should draw on the experience and resources of needle exchanges in the community, that it should contract out for the services of community needle exchanges, and that an institutional ethos must be created that favours needle exchange programs as a rational policy decision for all parties concerned.[337]

AVAILABILITY OF METHADONE

As stated by Harding and Schaller, "methadone maintenance in prisons may also be effective in reducing the risk of infection, and it is being adopted in some jails and a few long-term penitentiaries."[338,[43]] For example, in New South Wales (Australia), "[m]ethadone slowly insinuated itself into gaols, developing as 'the best game in town' to prevent needle sharing in the prison setting."[339] The experience with methadone has been described as follows:

> Five years ago, methadone was only an organisational irritant to the Prison Medical Service [PMS], requiring additional paper work and extra nursing input. About that time, AIDS

[42] For more details, see *HIV/AIDS in Prisons: Background Materials*. Appendix 5: Results of the Staff Questionnaire, and Appendix 6: Results of the Inmate Questionnaire.

[43] However, Harding has also pointed out that problems may occur on release for inmates on maintenance if access to a community program cannot be guaranteed, or when such inmates have to be transferred to prisons without methadone maintenance programs. See Harding and Schaller, infra, endnote 57 at 16.

> raised its head, and testing for the related antibody became available. The situation is now remarkably changed, with methadone being the "tail that wags the PMS dog." ... The main reason PMS promotes methadone in New South Wales is as an AIDS prevention strategy whereby it is hoped that needle sharing will be limited.[340]

Heilpern and Egger stated that "[i]ncreasing the number of places available for methadone treatment in the prisons should also be considered as a matter of urgency for HIV positive drug dependent prisoners."[341]

The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* recommend:

> 23. Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons.[342]

In Canada, methadone is given to some people under controlled conditions in community clinics, but rarely is it prescribed to anyone in prison. It has been argued that "methadone should be available within our prisons, especially to those with a long-term history of drug use associated with criminality" and that "[i]f methadone were available to these people it would not only eliminate their efforts to acquire illicit drugs while in prison, but it would also serve to accustom them to a lifestyle not centered around its acquisition."[343]

There are ample data supporting the effectiveness of methadone maintenance programs in reducing high-risk injecting behaviour and in reducing the risk of contracting HIV. It has been said that "methadone maintenance has a significant role to play in slowing the spread of AIDS ... and in the treatment of opiate dependence," and that "policy makers and programmes should take into account the need for methadone programmes in prisons as well as the advantages of offering methadone treatment as an alternative to imprisonment and other forms of criminalization."[344]

Many of the respondents to ECAP's *Working Paper* endorsed the Committee's conclusion that inmates dependent on drugs be given confidential access to methadone as one of the options for care and treatment available to them. Some regretted that the Committee had not devoted more attention to the issue of methadone maintenance. For example, Brian Kearns, the Acting Chief Executive Officer of the Alberta Alcohol and Drug Abuse Commission (AADAC), stated:

> One area where the paper seems to lack detail or debate concerns methadone maintenance. Given its effectiveness in reducing (if not eliminating) the use of narcotics, particularly through injection, this topic warrants greater attention as a harm-reduction strategy. From our experience at the AADAC Opiate Dependency Program, clients who are forced to withdraw from methadone because they are incarcerated usually return to narcotic use, often within the prison system, and often via injection.

Similarly, Dr. Alex Wodak, the Director of the Alcohol and Drug Service at St. Vincent's Hospital in Sydney, Australia, said that it was "surprising given the increasing evidence of the effectiveness of methadone in reducing HIV transmission among heroin injectors, that more prominence is not given to this intervention in your report."

ECAP'S ASSESSMENT

Prevalence of injection drug use

On numerous occasions ECAP was told by inmates that drug use, including injection drug use, occurs in federal correctional facilities. Many CSC staff, in their responses to the questionnaire ECAP sent them, also acknowledged that drug use is a reality in federal correctional

institutions.[44] More importantly, ECAP was told that needle sharing is frequent and that often 15 to 20 people will use one needle without cleaning it between each use. Compelling evidence for the need to avoid or reduce the harms from injection drug use is that in a prison in Scotland more than 15 inmates contracted HIV infection through the sharing of injection equipment within a period of only a few months.[345] Together with evidence collected from other sources, this led ECAP to conclude that injection drug use is likely to be the highest risk factor for HIV transmission within the correctional setting.

Reducing the harms from injection drug use

It is clear to ECAP that it is unrealistic to presume that drug use in prisons will stop or that drug injection will cease. Consequently, the Committee examined in great detail what might be done in federal penitentiaries to reduce the harms from drug use, and in particular what might be done to reduce the harms to inmates from their drug injection behaviour.

In many countries HIV has spread explosively among injection drug users. However, in some places, including some cities in Canada, the spread has been slowed dramatically. This is not attributable to efforts to suppress drug use, in particular injection drug use, nor is it attributable to the availability of drug treatment. It has occurred primarily because of a reduction in the sharing of uncleaned injection equipment. Prevention efforts have been directed toward educating drug users about HIV infection, about the importance of always using clean injection equipment, and in particular of not sharing equipment or else cleaning it before each use. These efforts have been accompanied by making bleach and sterile needles and syringes available, and by providing drug users with support services.[45] Importantly, these efforts have not increased injection drug use,[346] and they show that injection drug users can responsibly modify their behaviour to reduce the risks of HIV transmission.[347]

Efforts to implement a multitude of programs to prevent HIV infection among injection drug users have "led to the development of a philosophical perspective that informs much of the organized work."[348] This perspective has been called "harm reduction" or "harm minimization" and has been defined by Des Jarlais et al. as follows:

> The fundamental basis for the harm-reduction perspective is a pragmatic approach to the social and individual problems associated with the misuse of psychoactive drugs. That is, if drug misuse cannot be eliminated in the near term (or perhaps even in the long term), then at least some of the problems associated with the misuse of psychoactive drugs can themselves be reduced.[349]

As has been emphasized by Des Jarlais et al., "harm reduction" or a "health model" approach for dealing with drug use is "not necessarily liberal or conservative in conventional political terms," but should rather "be seen as a contrast between the utopian ideal of a 'drug-free society' versus a 'drug use without drug misuse' perspective."[350]

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[44] For more details, see *HIV/AIDS in Prisons: Background Materials*. Appendix 5: Results of the Staff Questionnaire.

[45] Perhaps the most complete evidence for the effectiveness of AIDS prevention for injection drug users comes from the Skane province of southern Sweden. Des Jarlais et al., infra, endnote 15 at 1061, describe HIV/AIDS prevention programs in that province as follows:

> AIDS prevention programs, including syringe exchange, education, referrals to drug-abuse treatment, and HIV testing and counselling, were established in the area in late 1986, when only a few of the local IDU were HIV-infected. There are an estimated 3000 IDU in the province, and 90% or more have been tested. Testing is routine at drug-abuse treatment programs, and all HIV-seropositives are reported to health authorities. Individuals who die from drug-related deaths are tested at autopsy; this has not identified any HIV-seropositives who were not already known to the health authorities. The current HIV seroprevalence among IDU in Skane is 0.2%, of whom four-fifths are known to have been infected with HIV before moving into the province. The seroprevalence for locally acquired HIV infections is thus only 0.04%, in contrast to 13% in Stockholm and 15% in Copenhagen, which is only a 30-40 minute ferry ride from Malmo, the largest city in the Skane province.

Equally impressive are the achievements of the needle exchange program in Vancouver, which has been described as the city's most important AIDS prevention program (see, e.g., Krueger G. Needle Exchange Program a Success for B.C. Project. *The Medical Post,* 14 May 1991 at 42).

"Harm reduction" or "health model" approaches for dealing with drug use have been adopted in many countries, including Canada, in response to the realization that the spread of HIV infection is a greater danger to individual and public health than drug use. They have led to the establishment of needle exchange or distribution programs in many communities. However, even communities that have adopted wide-ranging harm-reduction policies have often not extended these policies to prisons, and much remains to be done to reduce harms in this environment.[351]

ECAP considers that injection drug use is a serious danger to the health of inmates. In particular, it is a danger with regard to the transmission of infectious diseases such as HIV when uncleaned injection equipment is shared. In considering what might be done to prevent the transmission of HIV by injection drug use, ECAP confronted the following dilemma.

First, efforts by CSC to prevent drug use among inmates have to continue. Among the reasons for this are that possession of drugs is a criminal offence; that the use of drugs in penitentiaries is considered to be a threat to these institutions, in particular because of the association of drug use with violent, aggressive or other dangerous behaviour; and that public attitudes to drug use expect and demand these efforts. With regard to this last reason, ECAP repeatedly heard that staff and administration were adamant that drug use cannot and would not be tolerated in federal correctional institutions.

Second, ECAP found that it is unrealistic to presume that injection drug use can ever be fully suppressed in prisons, despite strong and persistent efforts by CSC to prevent drug use by preventing drugs from entering the institutions and through education about drug use and treatment of drug users. ECAP found that most administrators, staff and prisoners concur in this assessment.

ECAP observed that the risk of transmission of HIV and other blood-borne infectious diseases is directly related to the scarcity of clean injection equipment. This in turn is a consequence of the fact that possession of such equipment and of bleach is forbidden, which leads to efforts to confiscate injection equipment and bleach.

Since injection drug use in penitentiaries is unlikely to stop, ECAP found that the only way to prevent or reduce the transmission of HIV and other infectious diseases would be for inmates to always use clean injection equipment when injecting drugs. ECAP considered two alternatives for making this possible: making sterile needles and syringes available to inmates, and making bleach available to them. Because of evidence of the limited efficacy of bleach as a means of destroying HIV and the responses to its *Working Paper*, ECAP re-evaluated its original conclusion regarding this issue. ECAP believes that making sterile injection equipment available to inmates will be inevitable if efforts to prevent HIV infection in prisons are to be successful. However, ECAP believes that, at this time, it is not feasible to make sterile injection equipment available. Therefore, research that will identify ways to make needles available in a safe and confidential way in prisons has to be a priority. With regard to making bleach available, ECAP considers that, until sterile injection equipment can be made available to inmates, making full-strength household bleach accessible to all inmates in a discreet and easy manner, together with instructions on how to clean needles, is an immediate necessity. Therefore, ECAP concluded that, as an interim measure, bleach should be made immediately and widely available to inmates in federal penitentiaries.

MEASURES TO REDUCE DRUG USE

ECAP agrees that CSC has a responsibility to prevent the use of illicit drugs in federal correctional institutions. This means that CSC must continue to employ a full range of options in dealing with drug use, including efforts to prevent drugs from entering the institutions, confiscation of drugs, education about drug use and the harms deriving from it, and provision of access to rehabilitation and treatment programs for federal offenders. Many of these efforts are already in place, and ECAP has made suggestions as to

how some of them could be improved (see supra, section 5.2). With regard to drug-testing programs, ECAP shares the concerns that they could lead to increased harms, and suggests that in any decision about the extent to which they should be implemented, consideration be given to these concerns.

AVAILABILITY OF BLEACH

Making bleach available has been opposed on the grounds that it could be used as a weapon against staff. However, ECAP came to the conclusion that making bleach available should not be opposed on security grounds. ECAP is aware that many drug-injecting inmates covertly obtain bleach to clean their injection equipment and that this has not been associated with adverse consequences for staff or the good order of the institutions. This is consistent with the experience of those prison systems in which bleach has been made officially available, including that of British Columbia. Further, ECAP strongly believes that the use of clean equipment will not only prevent transmission of HIV infection among drug injectors but will also protect other inmates and staff. There will be fewer infected inmates in institutions and consequently less risk of exposure to HIV.

Making bleach available has also been opposed because it could be misinterpreted as condoning injection drug use and eroding efforts to prohibit drug use in federal penitentiaries. Staff have often expressed to ECAP their resistance to making bleach available, saying that it would be seen as sending out conflicting messages: prohibiting drug use and making strong efforts to prevent drugs from entering the institutions on the one hand; and on the other, acknowledging that an illegal act that has contributed to many prisoners being incarcerated in the first place is happening, and encouraging drug users to clean their equipment. However, ECAP believes that bleach should be made available to inmates and that this should not be seen as encouraging drug use, but rather as discouraging unsafe injection behaviour. Consistent with the recommendations issued by the U.S. Centers for Disease Control, bleach should be undiluted (full-strength household bleach), and clear instructions on how to clean needles most effectively should also be given to inmates. Making bleach available in no way condones drug use but, rather, emphasizes that in correctional facilities as elsewhere, the overriding concern in any effort to deal with drug use needs to be the health of the persons involved and of the community as a whole. Outside prisons this has been widely accepted, for instance by Canadian police forces. In a formal statement Vancouver police spokesperson Constable Scott Driemel gave the city's needle exchange unqualified support and said that "[t]he police recognizes the needle-exchange program is a vital necessity in safeguarding the health of those people using the program."[352]

Making bleach available is also mandated by the fact that, because prisoners have reduced possibilities of protecting their health, and because this results from state action, the state has special responsibility for their health: "As prisoner's rights as human persons are necessarily curtailed to some extent, they are also entitled to more protection."[353]

As has been argued by the Hon. Justice Kirby, President of the Court of Appeals of New South Wales in Australia, governments and prison administrators have the duty to face up to the risks of the spread of HIV infection, since "offenders are imprisoned as punishment and not for punishment."[354]

ECAP concluded that, in addition to making bleach available in federal penitentiaries, it will be important to review institutional policies concerning possession of bleach. This should be done in order to convince inmates that cleaning injection equipment must be a priority for them if they inject drugs, and to reassure them that they will not be punished for possessing bleach.

AVAILABILITY OF STERILE INJECTION EQUIPMENT

ECAP shares the concern that some inmates will not clean their injection equipment even if bleach is made available to them because of fear that

they might be discovered during the extra time it takes to clean the equipment. Therefore, and because of the serious doubts about the efficacy of bleach in destroying HIV, ECAP examined the more controversial issue of whether or not inmates should have access to sterile drug-injection equipment.

The scarcity of drug-injection equipment in correctional facilities almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment. Some injection drug users have stated that the only time they ever shared needles was during imprisonment and that they would not otherwise have done so.[355] Access to clean drug-injection equipment would ensure that inmates would not have to share their equipment.

However, making needles and syringes available in federal penitentiaries raises many contentious and potentially divisive issues and elicits fear among both inmates and staff. Because needles and syringes have not been made available in any prison system, data on the efficacy, benefits, risks, harms and cost-effectiveness of making them available are lacking. For example, it is not clear whether the model developed for needle exchange outside prisons could be adapted to prisons. Whereas the impact of needle distribution or exchange on levels of injection drug use outside prisons appears to be negligible, its impact in prisons is unknown. Safety and security issues also have to be examined, although there is no inherent reason to believe that the needles that would be made available would be more dangerous than those already present in penitentiaries.

Many organizations, groups and individuals have called for or supported making needles and syringes available in prisons, but many have also recognized that more needs to be known about how this might best be done. For example, Riley suggested that the development of syringes that could not be used as weapons has to be considered a priority, that a community-style syringe exchange raises problems of confidentiality for inmates, and that other solutions have to be worked out for prisons.[356] PASAN pointed out that a needle exchange program "must guarantee confidentiality" and that "without such a guarantee, prisoners will not make use of the exchange and the intervention will fail."[357] However, PASAN then suggests "that needles be exchanged through the health service" and that "prisoners should not be accountable to non-medical prison staff (including guards) when obtaining needles."[358] Since ECAP was often told that inmates would not go to the prison health service to ask for condoms for fear of being identified as engaging in sexual activity, the Committee does not believe that making needles available through the health service would solve the problem of confidentiality. Further, PASAN suggested that needles be exchanged in a "one-for-one manner," meaning that only those who already have a needle would be able to get a new one through the exchange.[359] This would ensure that the number of needles in the institutions would not be increased. However, it would also mean that inmates would still have to share injection equipment.

ECAP concluded that making sterile injection equipment available in prisons will be inevitable, particularly because of the questionable efficacy of bleach in destroying HIV. However, ECAP also concluded that sterile injection equipment cannot be made available immediately. In part, the reason for this is that making it available would not be acceptable to prison authorities, staff, inmates or the public. Another reason is that how to make it available in a safe and confidential manner is not known. Making sterile injection equipment available is a complex logistical problem and it requires appropriate consultation and planning. The sooner CSC addresses the problem, and initiates consultation and planning, the lower the HIV prevalence in prisons and the safer the prison environment for prisoners and for staff.

ECAP recommends that research be undertaken to identify ways and develop measures, including access to clean injection equipment, that will further reduce the risk from HIV transmission from injection drug use. This research should be carried out by individuals independent of but in collaboration with CSC, and include scientifically

valid pilot projects. It should include open consultation and public input from all interested parties – for example, inmates, staff, prisoner, health and community organizations, CSC, Health Canada, and the public, and should be accompanied by planning and education that will expedite making sterile injection equipment available in the institutions.

AVAILABILITY OF METHADONE

The Committee agrees with the statement of Harding and Schaller that "methadone maintenance in prisons may also be effective in reducing the risk of infection."[360] The Committee therefore considers that the care and treatment of drug users should include confidential access to methadone. Studies should be undertaken to establish the most effective ways of implementing methadone maintenance programs in penitentiaries.

RECOMMENDATIONS

MEASURES TO REDUCE DRUG USE

6.3 (1) ECAP recommends that CSC strengthen its efforts to prevent or reduce drug use and the harms from drug use and to care for and treat drug users in federal correctional institutions. This should include the evaluation of programs directed at reducing drug use and the harms from drug use, with participation of experts independent of CSC.

AVAILABILITY OF BLEACH

(2) ECAP recommends that full-strength household bleach be made available to inmates in federal correctional institutions as a general disinfectant. In particular:

- **small quantities of bleach and instructions on how to clean needles most effectively should be included in a "health kit" given to every inmate on entry into the institution and offered to every inmate on exit from the institution;**
- **bleach should be made available to inmates in a manner similar to that for condoms, dental dams and lubricant; that is, small quantities of bleach should be easily and discreetly accessible.**

(3) ECAP recommends that in making bleach available in correctional institutions, CSC's policies be revised as follows:

- **until bleach is made available, and thereafter, possession of small quantities of bleach should not be classified as an institutional offence, nor should it be considered to be presumptive evidence of illicit drug use.**

(4) ECAP recommends that the impact of making bleach available in federal correctional institutions be carefully evaluated, with participation of experts independent of CSC.

(5) ECAP recommends that, in order to re-emphasize CSC's strong commitment to reducing drug use in federal correctional institutions, making bleach available should be accompanied by a clear warning to inmates that possession or use of illicit drugs will not be tolerated in correctional institutions.

AVAILABILITY OF STERILE INJECTION EQUIPMENT

(6) In order to prevent the transmission of infectious diseases, in particular HIV, due to the sharing of unclean injection equipment, and because injection equipment may not be effectively or consistently cleaned by bleach, ECAP has concluded that access to sterile injection equipment by inmates must be addressed by CSC. Therefore, ECAP

recommends that research be undertaken that will identify ways and develop measures, including access to sterile injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use in federal correctional institutions. This research should be carried out with the active involvement of Health Canada and by individuals independent of but in collaboration with CSC. It should be preceded by consultation with inmates, staff, community groups and independent experts. It should include one or more scientifically valid pilot projects, and should be accompanied by planning, communication and education that will expedite making sterile injection equipment available in the institutions.

AVAILABILITY OF METHADONE

(7) In order to reduce the risk of infection from drug-injecting, ECAP recommends that the options for the care and treatment of drug users include access to methadone. Studies should be undertaken to establish the most effective ways of implementing methadone maintenance programs in penitentiaries. Once implemented, these programs should be evaluated, with participation of inmates and experts independent of CSC.

6.4 PREVENTING THE HARMS FROM TATTOOING

CURRENT SITUATION

Tattooing is a prohibited activity in federal penitentiaries. Although data on its prevalence is lacking, it is generally agreed that tattooing is a prevalent activity in most penitentiaries.

THE DEBATE

It has been said that "[o]utside tattooing is not thought to present much of a risk of HIV transmission because the needles are sterilised, but in prison tattooing is a social activity and involves sharing needles which may make it risky."[361] Similarly, Heilpern and Egger stated:

> It is difficult to estimate how much tattooing occurs in prisons although the visible evidence is often quite striking. Because the activity is illegal it is almost certainly conducted with non-sterile equipment. The evidence on the risk of transmission is also unclear. In 1988, HIV infection was reported in two ex-prisoners, and tattooing appeared to be the primary risk factor. ... Whilst this evidence is far from conclusive it does suggest that attention should be paid to non-sterile tattooing equipment in prisons.[362]

In Canada the following measures to reduce the harms from tattooing have been proposed. The Ontario Regional HIV/AIDS Advisory Committee recommended that each institution review its rules and regulations regarding tattooing and that tattooing be permitted but not encouraged in all institutions.[363]

PASAN stated that tattooing is "an art form in which many inmates engage" and that "[i]t can be practiced safely if new needles are used for each tattoo and if safety guidelines are followed."[364] PASAN therefore recommended that tattoo equipment and supplies be covered under "hobby-craft" and that expert tattoo artists should be brought into the prisons to help inmates learn to tattoo safely.

Heilpern and Egger stated that in Australia "[t]attooing is an integral part of the prison culture and will not be easily eliminated" and affirmed that "social and aesthetic judgments as to the merits of tattooing have no place in a HIV infection prevention program."[365] The authors presented the following three options for dealing with tattooing in prisons: (1) Increased surveillance and confiscation of equipment. According to the

authors this option would probably have little impact, given current experience with syringes, and may increase the risk that non-sterile equipment is used. (2) The provision of sterilizing equipment for tattoo needles. The authors believe that this option would be simple to implement and could be accompanied by an appropriate educational campaign about the risks associated with tattooing and the need for sterile equipment. (3) Allowing prisoners to engage professional tattooists. The authors believe that this option could also be easily implemented and accompanied by appropriate education.

Respondents to ECAP's *Working Paper* expressed mixed views on the Committee's conclusions. Some respondents opposed making available tattooing equipment, saying that CSC, rather than allowing this activity, should reinforce intolerance to it. The majority of respondents, however, agreed with ECAP's conclusion. One inmate stated that "tattooing and piercing are ancient art forms found in many countries" and that "if an individual chooses to become tattooed this is a personal choice." The inmate concluded by saying that the only form of "control" that a government should impose over those who choose to get a tattoo is to ensure that tattooing is conducted safely.[366]

ECAP'S ASSESSMENT

ECAP was told by inmates and by staff that in many penitentiaries tattooing is a prevalent activity. Because it is prohibited it is done covertly and often results in the sharing of needles. ECAP believes that it would be unrealistic to think that this activity will stop. The Committee therefore examined a variety of possible ways to reduce the risk of contracting infections through tattooing. ECAP found that authorizing tattoo equipment and supplies for use in the institutions was accepted, often reluctantly, by correctional authorities and staff, and was supported by inmates. Further, ECAP supports both making educational materials on how to safely tattoo available to inmates, and instructing inmates who would offer safe tattooing services to other inmates. ECAP does not see this as promoting tattooing in penitentiaries. The Committee believes that in dealing with the harms from tattooing, concern for the health of inmates needs to be the primary consideration. While continuing to discourage inmates from being tattooed in the first place, CSC should authorize sterile equipment for use in the institutions so that those inmates who nevertheless choose to be tattooed can avoid exposure to infections, HIV in particular.

RECOMMENDATIONS

6.4 ECAP considers that tattooing is a serious risk for the transmission of infectious diseases, including HIV, among inmates in federal correctional institutions. ECAP therefore recommends the following:

(1) Tattoo equipment and supplies should be authorized for use in the institutions.

(2) Educational materials on how to tattoo safely should be made available to inmates.

(3) Inmates who would offer tattooing services to other inmates should be instructed about how to use tattooing equipment safely, and be prohibited from tattooing until they are proficient in safer tattooing procedures.

(4) In the absence of such proficiency, institutions should consider giving inmates access to professional tattooists from outside the institution who can do this safely.

6.5 PREVENTING THE HARMS FROM PIERCING

CURRENT SITUATION

Piercing is another prohibited activity in federal penitentiaries. Although data on its prevalence is lacking, it is generally agreed that piercing is a prevalent activity in most penitentiaries.

THE DEBATE

The Ontario Regional HIV/AIDS Advisory Committee recommended that each institution review its rules and regulations regarding piercing and that piercing be permitted but not encouraged in all institutions.[367]

Responses to the *Working Paper* on this issue were similar to those ECAP received on the issue of tattooing.

ECAP'S ASSESSMENT

For the same reasons as for tattooing, ECAP considers that measures should be undertaken by CSC to reduce the risk of transmission of infectious diseases resulting from piercing with unclean equipment and supplies.

RECOMMENDATIONS

6.5 ECAP considers that piercing is a serious risk for the transmission of infectious diseases, including HIV, among inmates in federal correctional institutions. ECAP therefore recommends the following:

(1) Piercing equipment and supplies should be authorized for use in the institutions.

(2) Educational materials on how to pierce safely should be made available to inmates.

(3) Inmates who would offer piercing services to other inmates should be instructed about how to use piercing equipment safely, and be prohibited from piercing until they are proficient in safer piercing procedures.

(4) In the absence of such proficiency, institutions should consider giving inmates access to persons from outside the institution who can do this safely.

7. PROTECTIVE MEASURES FOR STAFF

CURRENT SITUATION

CSC has implemented a variety of measures to protect staff from exposure to and transmission of HIV and other infectious agents in correctional facilities. These include education about infectious diseases, provision of protective equipment, and development of infection-control guidelines.

With regard to educational programs for staff, Commissioner's Directive 821 reads as follows:

18. Regional Headquarters shall develop and coordinate a comprehensive educational effort directed at correctional staff and inmates. Specific components shall include:

a. education materials and opportunities to be provided as part of the orientation for staff and for an inmate entering the system, and to include information on how AIDS is transmitted, infection control measures and precautions to minimize the risk of transmission of HIV; and

b. opportunities for periodic information updates to ensure staff and inmates are kept informed on developments relating to AIDS.

As a result of the implementation of this policy, most staff have received education about HIV/AIDS. At the time of writing, educational programs were ongoing.

With regard to infection control, the Commissioner's Directive states:

14. For known or suspected cases of HIV infection, blood and body fluid precautions shall be instituted. Institutional health care staff, as subject matter experts, shall advise other staff regarding specific precautions.

15. Disposable gloves and resuscitation equipment and gowns shall be readily accessible to all staff, to be used at their discretion. Staff should be encouraged to use these when contact with blood or body fluids is anticipated, regardless of HIV infection status.

A revised version of Directive 821 (pending approval) encourages staff to use precautions universally, and not only with "known or suspected cases of HIV infection":

13. Staff shall be encouraged to use blood and body fluid precautions at all times, whether or not there is an identified risk of infection. Institutional health care staff shall advise other staff regarding specific precautions.

Guidelines for Infection Control were developed for staff in 1989, and contain information about the general precautions to be observed by all staff to prevent the spread of infection, as well as institutional procedures for cleaning and disinfecting the environment, equipment and supplies, cleaning of cells, kitchen and laundry, and "precautions to be observed with inmates identified as having an infectious disease."[368] These guidelines stress that blood and body fluid precautions need to be employed universally, "whether or not there is an identified risk," and that "[s]taff safety is enhanced by assuming that any individual may be infected by a communicable disease."[369]

Staff have been provided with protective clothing and equipment, and at the time of writing efforts were underway to further study staff needs in this regard.

THE DEBATE

There is general agreement that staff should continue to receive education about infectious diseases in general and HIV/AIDS in particular. For example, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that "[h]ealth authorities and persons responsible for correctional facilities ensure adequate and ongoing education/training on HIV/AIDS issues for their employees."[370]

PASAN recommended that HIV/AIDS education should be compulsory for all staff providing services for inmates,[371] and suggested that it should be a distinct and separate mandatory part of their orientation program at the beginning of employment and yearly thereafter.[372] Further, PASAN recommended that such education be comprehensive and should include, among other things, a review of how HIV is and is not transmitted, means of protection against HIV infection, community resources available to people with HIV/AIDS in the institutions and upon release, and universal precautions "reinforcing for staff and inmates that if these precautions are followed by everyone, there is no need to know a person's HIV status."[373] Education of staff should be done by external organizations and community groups "to ensure that the program and information both remain current, unbiased, and accurate, and discourage phobias and misinformation."[374]

The Ontario Regional HIV/AIDS Advisory Committee recommended that "[e]ducational efforts should be delivered towards both staff and offenders,"[375] and that a handbook on HIV/AIDS be developed for staff which should include information pertaining to modes of transmission, prevention, and treatment.[376] The Committee also recommended that a one-day workshop on HIV/AIDS for institutional physicians, chiefs of health-care services, and nurses be conducted.[377] This workshop, called "HIV in the Workplace: Knowledge is the Key to Prevention," was held on 13 October 1992. Following a plenary session, the participants broke into five groups to identify and discuss issues that were identified as potential risks or concerns. The following is a summary of some of the findings of the working groups.

The first group discussed the nature of exposures in the correctional environment. The group's conclusions may be summarized as follows: (1) Needlestick injuries are common, tracking mechanisms are inadequate and reporting is poor.

Needlesticks occur while providing immunizations or performing bloodwork on inmates. Sharps containers are often kept in locked cupboards and are therefore not available, which increases the risk of injuries. Special sharps containers that provide security for their contents as well as accessibility are required. (2) Slashings are the second most common type of blood exposure for health-care providers and security staff. Blood is occasionally collected by inmates and used as a weapon against correctional staff. Security staff are not knowledgeable about universal precautions and the infectivity of various body fluids. There are no standardized procedures or supplies for handling these situations. (3) Regular searches occur in some institutions and on an as-needed basis in others. Injuries occur from hidden needles, tattooing devices, razor blades, etc., during cell examinations. The ways in which such objects are hidden is often extremely difficult to detect in advance. Using heavy gloves would provide for safety but would make carrying out the search effectively very difficult because palpation is an important way to detect contraband. A working group of experts in this area may be required to determine the best protocol for searches. (4) Existing equipment and protocols are inadequate to provide appropriate care and universal precautions during emergency situations such as resuscitation. One-way-valve ambu bags, goggles, masks, gowns, etc. are required and there are new systems that limit exposures to needles during management of intravenouses. (5) Tuberculosis (TB) exposure is a concern to health-care staff, who have the impression that the number of inmates with positive Mantoux tests are increasing. Twenty-five percent are thought to be positive at Millhaven Institution, for example, a good number of whom are new immigrants. This is of increasing concern because of the documented increase in the rate of multiple-drug-resistant TB occurring worldwide, especially in some parts of the USA, with which we exchange inmates regularly. (6) Other body fluids – including feces, blood and semen – have been collected by inmates and thrown at correctional staff. (7) Suturing is performed by contract physicians. When a slashing occurs, the nurse on duty can elect to use bandages and steristrip the wounds. This may sometimes result in significant blood exposure, and protocols need to be developed to provide consistency about how this situation is approached. (8) Concern was raised that there is no standard protocol respecting the cleaning-up of blood spills. Cleaners are decided upon by each institution and it may be better to have a uniform policy and procedure for cleaning up blood and body-fluid spills. (9) Standardized protocols should be established, and search carts and emergency carts with appropriate barrier supplies should be stocked and checked on a regular basis. (10) There needs to be a process for evaluating new safety equipment and supplies before they are purchased and used in the correctional environment.[378]

The second group discussed issues related to the disclosure of offender medical information. These concerns are addressed supra, at 28-37.

The third group discussed the management of health-care workers exposed to blood and bloodborne pathogens in the correctional environment. Their conclusions may be summarized as follows: (1) Documentation, including a specific incident report form, is required and does not presently exist. (2) A Health and Welfare nurse who covers all of Ontario Federal Services cannot possibly track all such incidents. (3) No standard protocol for occupational health and safety in the area of bloodborne pathogens and exposure to blood and body fluids exists at CSC, and is urgently required. Each institution could have a dedicated occupational health and safety nurse who would be involved in education as well as tracking needlestick injuries and other possible exposure to bloodborne pathogen; incidents could be summarized and used to determine effective means of prevention. This person could also provide standardization of the medical follow-up of exposed health-care workers with respect to hepatitis vaccination, hepatitis B immunoglobulin and, where appropriate, AZT therapy when exposure to HIV has been shown to have occurred. At present, health-care staff do not have the authority to provide medical assistance to other health-care staff in their institutions.

(4) There should be consultation with experts in infectious diseases about prevention programs and about developing a protocol for post-exposure management of health-care workers. (5) The confidentiality of the exposed health-care worker must be maintained at all times. The advantage of a Health and Welfare nurse was that he/she kept separate records that were not part of the institutional records and therefore the level of confidentiality was high. Results could be summarized and provided to health-care administration for the purpose of determining the causes of needlesticks in an unlinked fashion. If each institution were to have its own occupational health and safety nurse, which appears indicated, some mechanism for confidentiality would have to be worked out. (6) The psychological impact of needlestick injuries and the concern they cause must be acknowledged, and efforts should be made to provide professional support for health-care staff in dealing with this level of stress. (7) Not enough emphasis has been placed on preventing needlestick injuries and other exposures to blood and body fluids in the correctional environment. This has to be the first priority, and an institutional occupational health and safety nurse may be able to take the lead and manage these activities at each institution.[379]

The fourth group discussed how universal precautions may be applied within CSC. Their conclusions may be summarized as follows: (1) Because institutions are different, protocols and procedures will differ from one institution to the next, although some standardization of protocols is essential. (2) The barriers to implementation of universal precautions are: financial commitment, which seems to be decreasing; the fact that nursing staff and security staff need to be educated; allocation of appropriate resources and freeing up of time for the nurses involved to allow implementation to occur; the unpredictable nature of the clients and the environment; the need for an occupational health and safety nurse who may also be involved with infection control, to implement universal precautions and maintain the educational process. (3) Some suggestions for the implementation of universal precautions are: standardization of protocols and procedures at institutions for the wearing of masks, gloves, gowns, and protective equipment; ongoing education, both when hiring staff and on a continuing basis; follow-up care for exposed health-care providers needs to be standardized and supervised by appropriate nursing and medical staff; safety equipment (e.g., emergency carts and search carts) should be used by all nurses and security staff and be provided in each work area as required; occupational health and infection-control nurses at each institution should be involved with the standardization process throughout CSC and be involved in establishing the training program.[380]

The fifth group discussed education regarding universal precautions at CSC and its conclusions may be summarized as follows: (1) Front-line staff, health-care providers, security staff, case managers, psychologists, instructors, etc., need education regarding universal precautions, and health-care management needs to be involved in establishing and maintaining the educational process. (2) Fears, negative attitudes and misinformation must be addressed. Very basic education is needed for most staff, with advanced education for the health-care providers who will act as resource persons within each institution. (3) The process of upgrading the level of knowledge regarding universal precautions of all CSC staff should begin immediately, and all correctional staff should receive basic universal precautions teaching during their correctional training. (4) The educator responsible for this must know each institution and its unique needs. At least one nurse or occupational health and safety and infection control manager/educator is needed for each institution, and in some larger institutions more than one will be required. This education requirement is necessary in order to decrease fears and effect a change in attitudes, starting with correctional officers and working toward other front-line staff, with an emphasis on long-range planning. At regional and national levels there is a gap between policy and reality that urgently needs to be closed. It is necessary to translate planning for the future into action now, using a fast-track approach. An appropriately qualified medical consultant in infectious diseases and infection

control should be sought by the Correctional Service of Canada to help with the implementation of infection control, universal precautions, and occupational health and safety. A working committee consisting of a designated occupational health and safety/infection control educator/nurse at each institution, together with the chiefs of health care and appropriate administrative staff and this medical consultant could go a long way to establishing uniform policy and procedures for implementation at CSC.[381]

The workshop issued recommendations that may be summarized as follows: (1) CSC should immediately begin the educational process concerning universal precautions for all staff. (2) CSC should provide the necessary equipment for the safe provision of health care and the handling of inmates' body fluids. This includes standardizing protocols for cleaning up blood spills and providing equipment for safe-search procedures as well as necessary emergency supplies. (3) CSC should provide for the immediate qualified medical follow-up of all staff exposed to the blood or high-risk body fluids of any inmate. (4) CSC medical staff should attempt to determine the infectiousness of the source inmate and provide for disclosure of this information when necessary for follow-up of exposed staff in a manner that ensures the confidentiality of both the inmate and the staff member. (5) CSC regional offices should seek the continued involvement of a qualified medical expert in infectious diseases to act as a consultant to CSC's occupational health and safety and infection control nurses. (6) CSC should hire an occupational health and safety and infection control nurse for each institution. The nurse would have the responsibility of educating staff and assisting in the development of protocols and procedures for the protection of staff and inmates. This person would be able to track each high-risk exposure and ensure that follow-up was initiated. (7) CSC should establish regional infection control committees. The complex and everchanging area of infection control requires a standing committee mandated to develop, upgrade and implement protocols and staff educational programs for the prevention of transmission of infections in the correctional environment. The two top priority items for this committee would be the application of universal precautions and prevention of tuberculosis. Membership should include a regional medical expert in infectious diseases and occupational health and safety and infection-control nurses, in addition to CSC administrative staff and representation from the inmate committees.

With regard to protective equipment and clothing, at the National Joint Occupational Safety and Health (NJOSH) meeting in May 1992 a proposal was made to study and recommend the "best approach to ensuring that staff have access to appropriate clothing and equipment that will provide protection against possible infection by an inmate who has an infectious disease."[382] As a result, a steering committee, acting as a subcommittee of the NJOSH, was established, and meetings were held "to identify the various clothing and equipment needs, depending on various scenarios in the institution and different work settings." As stated in the draft version of the committee's report, the committee "felt that it was important to ensure that the proper balance of theory and practicality was reached in making recommendations to ensure that staff would be adequately protected while still allowing them to be able to perform their duties unimpaired by cumbersome clothing or equipment."[383] The draft report continued by saying that a "trade-off needed to be made between something that would virtually guarantee against spread of infection under any circumstance and what was practical, likely to be used and reasonably priced."

The committee's discussions focused on the following areas: (1) identification of the occupational groups that would require the use of protective clothing; (2) identification of the tasks and situations that would necessitate protective clothing against infectious diseases; (3) the clothing that staff would require; (4) the location of the protective clothing and equipment; (5) the preparation of policy documents and guidelines supporting and enforcing the use of protective clothing.

The discussions "highlighted the importance of staff practising Universal Precautions" and it was emphasized that "[r]esearch of practices used in a multitude of settings in North America and Europe, indicated that these procedures in combination with appropriate clothing and equipment were commonly accepted as being adequate protection against the spread of infectious diseases."[384]

Clothing and equipment needs were identified with regard to specific work settings and job categories in CSC. A summary of some of the recommendations follows:

All correctional staff should be issued a small kit that could be attached to their belt, containing disposable latex gloves and a disposable airway for applying mouth-to-mouth resuscitation. In a situation where it is known in advance that an inmate will be uncooperative, the first approach would be to use something to try to subdue the inmate's aggressiveness, thereby reducing the risk of physical confrontation with the officer. Failing that, it is recommended that a water-repellent jumpsuit, helmet, waterproof and cut-resistant gloves, and mask be used. These clothes should be available in a central location in the institution and in sufficient numbers and sizes to ensure adequate coverage. For cleaning up body fluids, disposable latex "floor" gloves should provide sufficient protection. During cell searches, officers need to search in dark and inconvenient places for contraband and this sometimes involves using fingers to feel for things. Research is being done to find a way to use a machine (e.g., laser or scanner) that would be able to identify foreign objects. In the interim, the use of mirrors for viewing underneath objects is strongly encouraged so that officers will not prick themselves with a sharp object. A puncture-proof glove is also being investigated for its usefulness.[385]

The draft report concludes by saying that "[t]he Service has an obligation to protect its employees from being infected with any communicable disease" and that "[t]hrough input from local JOSH committees and collaboration with regional and national staff, an approach will be developed that will ensure that CSC staff will be properly protected."[386]

In Australia, it has been stated that "[t]he precautionary procedures to be followed by prison staff are essentially the same as for health workers."[387] The Australian Council of Trade Unions (ACTU) has listed the following three elements essential to a union response to HIV infection: (1) implementation of occupational health and safety guidelines on infectious diseases in the workplace; (2) provision of clear and accurate information on infectious diseases to all union members; (3) protection of union members, particularly those perceived to be at high risk of contracting HIV, from discrimination in the workplace.[388]

Heilpern and Egger have identified the following key elements of an effective occupational health and safety program: (1) staff education should stress the use of universal infection-control precautions and should include instructions on procedures to be adopted in a variety of specified situations involving contact with an inmate's blood or body fluids; (2) infection-control guidelines should be developed and disseminated widely throughout prisons, and there should be regular assessment respecting compliance with such guidelines; (3) while there is generally no reason to excuse staff at their own request from working with prisoners with HIV infection or AIDS,[46] special exemptions, for example for pregnant employees, may be desirable; and (4) no work restrictions need be imposed on correctional staff who are diagnosed as seropositive, whether transmission was work-related or not.[389]

The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* contain several recommendations regarding education of staff:

14. Prisoners and prison staff should be informed about HIV/AIDS and about ways

[46] In Canada, this issue was addressed in the case of *Walton*. See *HIV/AIDS in Canada: Background Materials*. Appendix 4: Canadian Case Law and Precedents.

to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release. The information should be coordinated and consistent with that disseminated in the general community. ...

15. Prison staff should receive HIV/AIDS prevention information during their initial training and thereafter on a regular basis.

17. Consultation with, and participation of, inmates and staff in the development of educational materials should be encouraged.

18. In view of the importance of peer education, both prison staff and prisoners themselves should be involved in disseminating information.[390]

Respondents to ECAP's *Working Paper* generally expressed agreement with ECAP's conclusions with regard to protective measures for staff. However, Dr. Rothon, Director of Health Services of the British Columbia Corrections Branch, was concerned that the *Working Paper* devoted insufficient attention to the funding and development of in-house resources for education on HIV/AIDS. In particular, she said that the needs of prisoners and staff in correctional facilities are often very specific, and claimed that many external, community-based AIDS or prisoner organizations have often been "ill-informed and ill-prepared to deliver accurate, unbiased and up-to-date information and have resembled prisoner and patient advocacy groups more than teaching organizations."[391] She therefore supported a strong in-house educational program staffed by competent health educators contracted jointly to federal and provincial correctional services.

ECAP'S ASSESSMENT

ECAP strongly believes that staff concerns for their safety have to be taken very seriously. In order to learn more about these concerns, the Committee met with staff during its prison visits, sent a questionnaire to staff, and consulted with the Union of Solicitor General Employees. ECAP recognizes that the protection of staff against the risks of HIV transmission is clearly an important obligation borne by CSC. ECAP further acknowledges that there are many situations in which staff may potentially be exposed to infectious diseases, including HIV infection. Such situations include conducting body and cell searches, performing emergency first aid where blood or other body fluids are present, controlling aggressive inmates, and supervising the cleaning-up of blood and body fluids.

ECAP commends CSC for its efforts to protect staff against exposure to and transmission of infectious diseases. These efforts have included education about infectious diseases and the risk, or absence of risk, of transmission of infections in the workplace, the issuing of infection-control guidelines, and the provision of protective clothing and equipment to staff. However, staff's concerns about and fear of being infected with infectious diseases, in particular with HIV, during the course of their work persist, as do misperceptions about the risk of HIV infection attributable to work in federal penitentiaries. ECAP identified a variety of measures that could be undertaken by CSC to provide staff with increased protection and alleviate their concerns and fears.

Education and training

ECAP considers that education is the best prevention. The Committee acknowledges that CSC has made a major effort to educate its staff. As a result, staff are generally well-informed about HIV/AIDS. However, some staff reported to ECAP that they had not received education about HIV/AIDS or that it had been provided to them a long time ago and had not been updated. Other staff, although they had received education, had unnecessary fears and misperceptions about HIV transmission. The analysis of the results of the questionnaire that ECAP sent to staff reveals that staff consider that they need and should receive

more and updated education and information.[47] ECAP believes that education and information should be provided on a regular basis. Consultation with, and participation of staff in the development of educational materials should be encouraged, and, in view of the importance of peer education, prison staff should be involved in disseminating information and delivering educational sessions. Finally, the credibility of education and information would be further improved by asking experts or external, community-based AIDS and health organizations to provide input.

Further, an increased effort could be made to train staff to apply infection-control procedures and practices universally whenever they may be exposed to an inmate's blood or body fluids. This would include educating staff about the need to always comply with universal precautions when confronted with such situations, and not only when this is convenient or when an inmate is known to be infected. In particular, ECAP does not believe that revealing the HIV status of known infected inmates to staff would increase staff safety. On the contrary, ECAP is convinced that this would be counterproductive in terms of their safety, in particular with regard to efforts to educate staff to always use universal precautions. A brief, authoritative document on HIV/AIDS, tailored for correctional service staff, could be developed to address the fact that there is a low risk of contracting infections when working in the correctional environment and that there are ways in which this risk may be reduced or avoided.

Further, ECAP considers it essential that there be continuing education of staff about how to react to "risky situations," such as when inmates are violent. ECAP agrees with the finding of one of the working groups at the workshop on HIV/AIDS recently held in the Ontario Region that "not enough emphasis has been placed on preventing needlestick injuries and other exposures to blood and body fluids in the correctional environment."[392] The working group concluded that "[t]his has to be the first priority."[393] ECAP acknowledges that staff cannot always avoid exposure and that they will sometimes be unable to use precautions, such as when they are assaulted by inmates. Nevertheless, as was stated in the report of the committee studying protective clothing and equipment, there are many situations "where it is known in advance that the inmate will be uncooperative."[394] ECAP agrees with the committee's assessment that in such situations "the first approach would be to use something to try to subdue the aggressiveness of the inmate, thereby reducing the risk of physical confrontation with the officer."[395]

Infection-control guidelines

ECAP commends CSC for having developed infection-control guidelines for staff. However, the Committee believes that these should be reviewed on a regular basis and updated as the need arises.

Provision of protective equipment

ECAP strongly supports the findings of the report of the committee studying protective clothing and equipment (see supra, at 85-86) and encourages CSC to act upon its recommendations.

Follow-up of exposure

ECAP considers that any incident involving exposure to blood or body fluids should be immediately followed up and that procedures should be developed for doing so. Such situations are relatively common in health-care settings, and there is extensive experience concerning the management of them. Follow-up would include a written report about the incident and a medical assessment of whether there has been a potential risk of HIV transmission. In most cases, such as when staff have been bitten or spat upon, there will be no risk or minimal risk of HIV

[47] For more details, see *HIV/AIDS: Background Materials.* Appendix 5: Results of the Staff Questionnaire.

transmission.[48] It should be noted that there has been only one documented case of occupational transmission in any prison in the world.[49]

Following exposure, staff should be offered counselling and psychological support. Where it is established that there has been a risk of HIV transmission, early medical intervention should be available, including prophylaxis with AZT and referral to specialists familiar with the problem. At the same time, the person who is the source of the exposure should be encouraged to volunteer information about his or her HIV status. Those who do not know their HIV status should be encouraged to undergo voluntary HIV testing.

Family and partner support

ECAP considers that the families and/or partners of staff should be encouraged to participate in educational sessions on HIV/AIDS. Further, they should have access to counselling and psychological support at their request whenever the partner has potentially been exposed to HIV.

ECAP is convinced that what are often perceived as conflicting interests between staff on the one hand and prisoners on the other are really compatible interests. For example, measures that will protect inmates, such as providing them with education and the means to protect themselves against HIV infection (including bleach), will also benefit staff and the public because they will result in fewer infected inmates being housed in the institutions and in fewer infected inmates being released into the community after serving their sentences. Equally, the measures that will protect staff from contracting HIV infection, namely education and the application of universal precautions, are compatible with the inmates' interest in seeking out counselling and HIV testing and in maintaining their medical information confidential until they decide themselves to share it with others.

RECOMMENDATIONS

7. ECAP considers that education about HIV infection and AIDS is the most important effort to promote and protect the health of staff and prevent transmission of HIV and other infectious agents in federal correctional institutions. ECAP therefore recommends that existing educational efforts be improved by the following:

(1) All staff should receive written information about HIV infection and AIDS. This could be in the form of a brief, authoritative document prepared by an outside organization or expert and tailored for CSC staff. It would point out the low risk of contracting infections through working in the correctional environment and indicate ways in which this risk may be reduced or avoided.

(2) All staff should receive educational sessions about HIV infection and AIDS, including the subject of universal precautions, when they begin their employment and on a regular basis thereafter. Consultation with, and participation of, staff in the

[48] This was recently acknowledged in the case of *Lesieur*, in which an inmate who knew that he was HIV-positive tried to bite CSC staff. He then sprayed them with his blood, saying he would thus contaminate and kill them. The inmate was charged with a number of offences, including attempted murder. On 17 February 1993 a jury returned a guilty verdict on charges of assaulting a peace officer, uttering threats to cause death or serious bodily harm, and assault causing bodily harm. However, the inmate was found not guilty on the charge of attempted murder (see *HIV/AIDS in Prisons: Background Materials*, Appendix 4: Canadian Case Law and Precedents). In another case, decided in November 1992, another federal HIV-positive inmate was convicted of assault and sentenced to six months' imprisonment after he bit a correctional officer at Port-Cartier Institution. These cases clearly show that courts acknowledge the absence of risk of HIV transmission in such incidents.

[49] This case occurred in Australia. It was alleged that a young officer, newly recruited to the service, was attacked and stabbed with a blood-filled syringe. The officer later tested positive for HIV. The incident was widely reported in the press. See Doyle J. Management Issues – A Prison Officers Union Perspective. In: *HIV/AIDS and Prisons*, infra, endnote 134. Until July 1990 there were no known cases of occupational transmission among correctional staff anywhere in the world. See Hammett, infra, endnote 64.

development and implementation of these sessions should be encouraged.

(3) External, community-based AIDS and health organizations or experts should be invited to participate in these sessions.

Further, ECAP considers that, for staff to protect themselves, access to and the correct use of materials and equipment with which the risk of transmission of infectious diseases, including HIV, may be reduced, are essential. ECAP recognizes that materials and equipment are already available in federal correctional institutions. However, in order to reassure staff and to ensure continued proficiency in the use of such materials, equipment, and protective procedures and practices, ECAP recommends that CSC undertake the following:

(4) Protective protocols and staff compliance with them should be reviewed regularly.

(5) Access to and use of protective materials and equipment should be reviewed regularly.

(6) The necessary equipment for the safe provision of health care and the handling of body fluids should be provided. This includes standardizing protocols for cleaning up blood spills and providing equipment for safe search procedures as well as necessary emergency supplies. In particular, CSC should consider provision of so-called puncture-resistant or cut-resistant gloves to replace latex gloves for use when handling emergency situations, dealing with aggressive or violent inmates, and carrying out searches.

(7) The follow-up, including medical follow-up, of all staff exposed to the blood or blood-contaminated body fluids of any inmate or fellow staff should be provided.

(8) The families and/or partners of staff should be encouraged to attend the educational sessions, and should have access to counselling and psychological support whenever their family member or partner has potentially been exposed to HIV.

8. HEALTH CARE

CURRENT SITUATION

In 1988, CSC's Health Care Services Branch adopted national standards for health care "to ensure that offenders receive up-to-date care throughout their sentences, care which is comparable to that available in the community."[396] According to the document, Standards for Health Care,[397] the objectives of CSC Health Care Services are as follows:

> Although the offender has the primary responsibility for his/her own health status, CSC is responsible for ensuring appropriate, equitable and adequate access to professional physical and mental health services. These services contribute to the offenders' adjustment within the institution and assist them to become law-abiding citizens by:
>
> 1) identifying through assessment/diagnostic services the needs of individual offenders and special categories of offenders amenable to assistance from health services;
>
> 2) providing services and continuity of care for offenders suffering from physical, psychiatric, emotional, social or behavioral difficulties, at standards of professional quality consistent with those governing the provision of services to the Canadian public in general; and
>
> 3) providing advice or guidance as subject matter experts for the purpose of

strengthening an overall, integrated CSC physical and mental health service.[398]

In order to ensure an integrated, comprehensive service from the admission of an offender until his or her release, the following principles were established:

1. A multi-disciplinary approach to the provision of care to the offender throughout his/her sentence shall be implemented;

2. The offender retains the primary responsibility for maintaining and improving his/her health status, notwithstanding the constraints inherent to the correctional environment;

3. The offender is entitled to reasonable access to the full range of health services, including prevention, treatment and rehabilitation, in accordance with generally accepted community standards;

4. Health service delivery shall be appropriate to the offender's age, sex and condition and shall respect the individual's religious or cultural values;

5. The offender, who is of sound mind, has the right to refuse health treatment or advice except where otherwise provided by law. The health professional is obligated to provide the necessary information to enable the offender to make an informed decision;

6. The offender has the right to have medical information dealt with in a confidential manner. Standards of confidentiality shall be consistent with professional standards, Commissioner's Directives, the Privacy Act and other federal legislation;

7. Current professional standards promote the obtaining of a second opinion where there is a margin of doubt. CSC shall provide this service upon the request of the physician. However, second opinions initiated by the offender may be permitted at the offender's own expense;

8. The health delivery system within CSC must meet the requirements of existing federal laws and applicable provincial legislation;

9. The health delivery system shall be based on the community health model, with a focus on the health of the prison community as a whole, by intervention at the individual and group level. The curative and preventive services offered shall be coordinated to encourage continuity of care for the duration of the sentence;

10. The health services shall be provided by health professionals/practitioners currently registered/licensed (or eligible for registration/licensing) in Canada and preferably in the province of practice;

11. The range and level of health services available to offenders shall be established in policy and audited on a regular basis; and

12. All research undertaken shall be approved by a research review committee charged with the responsibility to ensure that ethical standards, proper design and supervision are met, and that the full voluntary and informed written consent of the participant is obtained.[399]

A list of standards for the delivery of Health Care Services to offenders within CSC was drawn up. These standards "must be considered when programs are being developed and delivered,"[400] and include, among others:

- Informed Consent and the Right of Refusal

  Informed consent of a mentally competent offender shall be obtained before commencing a treatment program and such an offender shall have the right to refuse treatment.

- Research

  Any research which involves offenders as subjects, shall be approved by a research review committee. This committee shall ensure that all research meets the highest ethical standards and has proper design and supervision. Offender participation shall be contingent upon voluntary and informed written consent.

- Levels of Service

  The Correctional Service of Canada shall ensure the provision of a range of health services for offenders including mental health and general health care. Services shall be available at a primary, intermediate and intensive or tertiary service level.

  Criteria

  1) Primary level of service shall be provided on an ambulatory basis to offenders who remain in general population.

  2) Intermediate level of service shall be a specialized program delivered in a dedicated living space within a regular institutional setting.

  3) Intensive/tertiary level of service refers to in-patient beds in a facility designated under mental health legislation or to in-patient beds in a general hospital.

- Access to Services

  Offenders shall have access to health services on a 24-hour basis.

  Criteria

  1) Clustering of all services, where proximity of institutions allows for cost effective use of it, shall be implemented.

  2) Where 24-hour nursing coverage is not provided on-site, staff with basic first aid and cardio-pulmonary resuscitation (CPR) training will be on duty.

  3) Nursing services shall be provided 24 hours per day in institutions where in-patients are cared for (Intermediate level).

- Referrals

  Referrals to outside agencies for consultation, treatment and surgery shall be for essential services. Essential services can be categorized as emergency, urgent or non-urgent.

  Criteria

  1) Emergency: a case where delay will endanger the life of the offender.

  2) Urgent: the condition is likely to deteriorate to an emergency or it is interfering with the offender's ability to carry out his or her activities of daily living.

  3) Non-urgent: the condition is not affecting the offender's activities of daily living now, but may in the future.

- Admission Assessment

  Assessment of all offenders' health status shall be completed on admission.

The *Corrections and Conditional Release Act* also emphasizes health, safety and personal dignity. Further, it prohibits any treatment that is cruel or degrading and seeks to ensure that standards comply with United Nations treaties and the *Canadian Charter of Rights and Freedoms.* The relevant provisions of the *Act* read as follows:

> 86.(1) The Service shall provide every inmate with
>
> (a) essential health care; and
>
> (b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.

86.(2) The provision of health care under subsection (1) shall conform to professionally accepted standards.

87. The Service shall take into consideration an offender's state of health and health care needs

(a) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and

(b) in the preparation of the offender for release and the supervision of the offender.

With regard to treatment, s. 88 of the *Act* provides that offenders must give their informed consent to any treatment, have the right to refuse treatment, and may participate in research projects, but only if they give informed consent and if an independent committee has reviewed the case and approved the project.

In accordance with these provisions and the above standards, every inmate entering the federal penitentiary system goes through a thorough health assessment. This includes screening for tuberculosis. Inmates are also offered hepatitis B vaccination.

THE DEBATE

CSC makes major efforts to ensure that the quality of care available to inmates in the federal corrections system is on a par with that available to Canadians generally.[401] It has mandated its external Health Care Advisory Committee to monitor these efforts.

Nevertheless, prisoners with HIV infection have sometimes complained that they have not received adequate medical care.

The Federal/Provincial/Territorial Advisory Committee on AIDS has recommended that all inmates have access to "medical, nursing, in-patient and out-patient services equivalent to those available in the community at large."[402]

PASAN has recommended that "[p]risoners with HIV/AIDS must be guaranteed access to medical and dental workers of their choice" and that "they must have access to experienced and expert HIV primary care physicians."[403] Further, it has been suggested that a comprehensive plan for the medical and psychosocial care of prisoners with HIV infection should be developed,[404] and that prison populations be included in research on new treatments for HIV infection and AIDS.

The Ontario Regional HIV/AIDS Advisory Committee recommended a variety of measures to establish "strong and effective links with community treatment programs in order to facilitate their work with offenders, both outside and within CSC facilities." In particular, the Committee recommended that the Chief of Health Care Services and the Deputy Warden, Correctional Operations, of each institution, in consultation with the visiting physician, ensure that appropriate facilities are available for the provision of confidential assessment and treatment services to inmates and that these services also provide the highest level of security.[405]

The Committee also addressed concerns about the privacy and security of inmates escorted to outside HIV/AIDS clinics, and examined the issue of the sharing of information with community agencies assisting CSC in the management of offenders with HIV/AIDS, and the provision of services to an institution located at a great distance from available community services.

A "Review of HIV/AIDS and Related Issues" was undertaken on 23 June 1993 at Matsqui Institution by a team of experts from St. Paul's Hospital/Vancouver. In its report, the team highlights current areas of strength in dealing with HIV/AIDS in the institution, and identified opportunities for further improvement. The team recommended that "specialized educational efforts be undertaken to ensure that HIV infected individuals and those afflicted with symptomatic disease have available to them the necessary

expertise required to deal with this problem." It further suggested that "it would not be practical for the Institution to develop in-house expertise at the specialty level," but that it "would be desirable to expose a selected number of staff members to the HIV problem through a brief rotation through a specialized Institution such as St. Paul's Hospital."[406] The team further suggested that inmates be given access to open telephone lines, because this would facilitate counselling and education of inmates by third parties outside the correctional system as well as peer and family support. Finally, the team recommended that the institution establish a system to evaluate its HIV/AIDS-related activities, and that an assessment of knowledge, behaviours and attitudes regarding HIV/AIDS could be undertaken on a yearly basis to assess the impact of the measures taken.

Internationally, there is emerging agreement that, with regard to access to health care, the same standards that apply outside prison should apply to prisoners.[407] This was stated, for example, in the United Nations "Basic Principles for the Treatment of Prisoners"[408] and in the third annual report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.[409] The World Health Organization stated that this principle of equivalence should apply to HIV/AIDS.[410,[50]]

In the United States, the principle was reaffirmed by the Presidential Commission on the HIV Epidemic, which recommended that "[c]are and treatment available to HIV-infected inmates in correctional facilities should be equal to that available to HIV-infected individuals in the general community,"[411] and by the National Commission on AIDS:

> Individuals who test HIV positive need to be properly examined and regularly monitored by a physician who is knowledgeable about infectious disease and keeps abreast of medical developments in HIV treatment. The full range of approved medications to prevent or treat symptoms of HIV disease must be available in order for the promise of early intervention to be fulfilled.[412]

The Commission acknowledged that, "[b]ecause treatments for HIV disease tend to be novel, experimental, and expensive, HIV disease tests the limits of prison health care."[413]

With regard to participation in clinical trials, the Commission stated that "[a]s new drugs become approved and available through clinical trials, prisoners should and can be permitted to choose to participate in clinical trials, while remaining protected from coercion and abuse."[414] The Commission concluded that adequate care in correctional facilities includes, but is not limited to: meaningful access to HIV testing; regular examinations by physicians with sufficient training to diagnose and treat HIV infection and HIV-related illnesses; a full physical examination at the time infection is diagnosed, and subsequently as medically indicated; access to necessary specialist care where appropriate; T-cell monitoring at the intervals prescribed by the U.S. Public Health Service; timely, consistent and appropriate access to necessary medications, including prophylactic drug therapies approved by the Food and Drug Administration or recommended by federal health authorities; access to dental care; access to mental health care; access to meaningful drug treatment on demand; clean, hygienic housing facilities; and appropriate diets.[415]

Similar recommendations were made by the United States National Prison Project.[416]

In Australia, Heilpern and Egger acknowledged that "[t]o provide an equivalent medical service to that available in the community, in a prison setting, is a formidable task for both prison administrators and health authorities."[417] They recommended that policies and plans be prepared to meet a potential increase in the number of seropositive prisoners likely to develop symptoms

[50] For more details, see *HIV/AIDS and Prisons: Background Materials*. Appendix 2: International Prison Policies Relating to HIV/AIDS.

while serving prison sentences, and that these policies should address: the development of criteria to ensure that prisoners receive medical care equivalent to that provided in the general community; the evaluation of existing medical services against these criteria; planning to develop cooperative programs with the Department of Health; the long-term resource needs of prison medical services; and accessibility of community-based multidisciplinary services.

Summarizing the situation with regard to medical care at the international level, Harding and Schaller have stated:

> Some prisoners receive up-to-date, state-of-the-art specialized care for their HIV disease. Many do not. Expensive treatments may not be financed by prison services; many therapies, such as aerosolized pentamidine, are not available to inmates unless they are hospitalized. In many instances, overstretched prison medical facilities are unable to organize and maintain the necessary care.[418]

The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* contain the following provisions with regard to care and support of HIV-infected prisoners:

34. At each stage of HIV-related illness, prisoners should receive appropriate medical and psychosocial treatment equivalent to that given to other members of the community. Involvement of all prisoners in peer support programmes should be encouraged. Collaboration with health care providers in the community should be promoted to facilitate the provision of medical care.

35. Medical follow-up and counselling for asymptomatic HIV-infected prisoners should be available and accessible during detention.

36. Prisoners should have access to information on treatment options and the same right to refuse treatment as exists in the community.

37. Treatment for HIV infection, and the prophylaxis and treatment of related illnesses, should be provided by prison medical services, applying the same clinical and accessibility criteria as in the community.

38. Prisoners should have the same access as people living in the community to clinical trials of treatments for all HIV/AIDS-related diseases. Prisoners should not be placed under pressure to participate in clinical trials, taking into account the principle that individuals deprived of their liberty may not be the subjects of medical research unless they freely consent to it and it is expected to produce a direct and significant benefit to their health.

39. The decision to hospitalize a prisoner with AIDS or other HIV-related diseases must be made on medical grounds by health personnel. Access to adequately equipped specialist services, on the same level available to the community, must be assured.

40. Prison medical services should collaborate with community health services to ensure medical and psychological follow-up of HIV-infected prisoners after their release if they so consent. Prisoners should be encouraged to use these services.[419]

Respondents to ECAP's *Working Paper* generally agreed with the Committee's conclusions on health care for inmates with HIV infection or AIDS. However, both the Canadian AIDS Society and the National Advisory Committee on AIDS (NAC-AIDS) expressed concern with the possible consequences of ECAP's conclusion that infected prisoners ought to be treated in the community:

> NAC-AIDS is concerned that unequal standards of care will be accepted within the penal system. There can be no doubt that inmates in or around Vancouver, Montreal or Toronto receiving care at the level commonly

> found in those cities will be much better cared for than inmates from some of the rural areas with a very low prevalence of HIV disease. We acknowledge that Corrections Canada cannot itself solve the inequities in care across Canada. However it is their responsibility to ensure an appropriate standard of care necessary for PLWHIV/AIDS [Persons Living With HIV Infection or AIDS]. Staff training, facilitating external care and even long distance medical consultations, and educating staff to the often immediate need for treatment are but a few practical suggestions. Commitment to care will often exceed what is available "down the street" especially for the federal institutions located in more isolated parts of Canada. This issue needs to be a factor in parole.[420]

One respondent suggested that the assessment of health-care services in each institution should be undertaken by an independent panel to ensure that it will be both fair and impartial.[421]

ECAP'S ASSESSMENT

ECAP commends CSC, and in particular CSC's health-care services, for the efforts made to provide HIV-infected inmates with quality medical care. In particular, ECAP recognizes that there is genuine concern and effort to provide inmates with health care that is comparable to community standards outside prisons. This includes efforts to assess the quality of services in place and to respond to emerging trends, innovations and problems in health care, in particular through CSC's Health Care Advisory Committee.

Attesting to this, ECAP heard from some inmates with HIV infection and from those who care for inmates with HIV infection or AIDS, that the care that inmates with HIV infection or AIDS receive may be better than the care that would be available to them outside prison. Nevertheless, ECAP was informed of instances in which inmates with HIV infection have not had access to medical care that would have been available to them outside.

ECAP has identified at least three reasons for this problem, namely: the restricted mobility of inmates; medical coverage when illnesses occur; and the capacity of medical services to expeditiously provide care and treatment.

Restricted mobility of inmates

Access to health care for persons with HIV infection or AIDS who live outside prisons is relatively uncomplicated and efficient. Usually they need only arrange an appointment with their physician or go to a clinic or hospital to obtain the care they may require. For inmates, access to specialized health care necessitates arranging for a visit to a physician, clinic or hospital outside the correctional facility, or waiting until this service is available in the institution. Interim services are provided by the prison health services. HIV infection and AIDS are complex diseases that often require expertise not widely available in Canada, including inside correctional facilities. Logistical problems in safely transporting inmates to where this expertise is available or in having experts visit an institution may require justification that the care is necessary at a particular time, and may lead to delays or to the perception that care is not accessible. These problems may be aggravated by the security arrangements required for transporting inmates. Some of these problems are analogous to those of persons living outside prison in remote areas, and the solutions to them involve balancing needs, benefits, costs and logistics. Sometimes the only effective solution may be for the person to relocate nearer to the required services. In the context of federal penitentiaries, relocation of inmates who require very complex or urgent care may be one solution to this problem. Another may be for prison health services to ensure that their medical staff are proficient in providing this care. However, this solution is not possible without the trust and confidence of the inmate in the services available.

Medical coverage when illnesses occur

Although the onset of diseases such as immunodeficiency, wasting, or neurological

disease attributable to HIV infection is a slow process, secondary infections or complications from these diseases or their treatment may develop rapidly and require urgent care. Examples include herpes simplex or herpes zoster infections, Pneumocystis carinii pneumonia and Toxoplasma meningoencephalitis. Development of such diseases at "off hours" or in institutions without physician coverage is a problem aggravated by the restricted mobility of inmates and their vulnerability to judgment by non-medical staff. Again, there would not appear to be any simple solutions to this problem. Among the possibilities are relocation of inmates, increased staffing and services, and communication with health-care personnel that bypasses staff decision-making concerning the need for such communication.

Capacity of medical services to provide care and treatment

The growing complexity of care for HIV-infected inmates or inmates with AIDS poses difficult operational and logistical problems for prison health services (for example, access to new and often experimental treatments, access to special diets, availability of diagnostic tests that are often available only at tertiary-care centres, access to psychosocial support, in particular that provided by peers or community organizations, and access to research studies). These problems are not unique to inmates with HIV infection or AIDS, but the growing diagnostic and treatment burden relating to this disease requires that they be solved as soon as possible. Among the possible solutions are prisoner relocation at their demand, increased staffing and services, recognition by staff that such care is not only necessary but that inmates are entitled to it, and closer liaison with outside health-care and community services.

ECAP recognizes the economic, security, administrative and geographic constraints imposed on health-care services in federal penitentiaries. Balancing the health needs of inmates with the availability and accessibility of services is not a simple problem, and ECAP considers that greater study is required to solve it than the Committee could provide. At the same time, the Committee considers that changes that could provide interim improvements in this system could be implemented. These changes are designed to improve trust and confidence of inmates in this system, in particular by enhancing opportunities to access new treatments and peer or community counselling and support services. ECAP further recommends that the approach provided by the Ontario Regional HIV/AIDS Advisory Committee be followed, namely that health services in each institution be assessed to ensure that the expertise necessary for the medical care of inmates with HIV infection or AIDS is available. This evaluation should be done by external experts in collaboration with internal health care and administrative staff.

RECOMMENDATIONS

8. **ECAP agrees that the care of inmates in federal correctional institutions should be comparable to that available in the community. In the context of HIV/AIDS, this includes access to new, experimental or special treatments, special diets, and peer and community-based organization counselling and support. ECAP acknowledges the efforts that CSC's Health Care Services have made to provide inmates with HIV infection or AIDS. However, in order to meet the community standard, ECAP recommends the following:**

   (1) Health-care services in each CSC region should be assessed in consultation with outside experts to ensure that the expertise necessary for the medical care of inmates with HIV infection or AIDS is available, and that the services for dealing with the care of inmates with HIV infection or AIDS will be efficient and accessible.

   (2) Incarceration should not be an impediment to accessing new or experimental or special treatments for HIV infection, AIDS or their associated diseases, or for enrolling in research studies; inmates should have the

opportunity to relocate to another institution, subject to security considerations, when such services or treatments are unavailable or inaccessible in their institution.

(3) Strong and effective links with external health-care services should be established to ensure that the care of inmates with HIV infection or AIDS is efficient and accessible, and that continuity of care is provided for whenever they are transferred, given temporary absences, or are released.

(4) External community-based AIDS or health organizations should be readily accessible to inmates with HIV infection or AIDS.

(5) In each institution, CSC should create or designate one or more inmate jobs as peer health counsellors, and provide for appropriate training, support and evaluation.

9. TUBERCULOSIS

CURRENT SITUATION

In order to prevent the spread of tuberculosis (TB)[51] in federal penitentiaries, in 1990 CSC adopted a policy that provides for voluntary TB testing of inmates entering the correctional system. Unless there is documented evidence available that a TB skin test was done prior to admission, inmates are Mantoux or tuberculin tested upon entry into the federal institution. Inmates are exempt from the test only when they have tested positive on a past occasion. When, on admission, an inmate has a positive reaction to the TB skin test, has had a positive skin test in the past, has received BCG, or refuses TB skin testing, he or she will be screened for TB by chest x-ray. If the x-ray suggests active disease, a sputum specimen is tested for the presence of TB. When it is confirmed that an offender has tuberculosis and is infectious (that is, has "active" TB), he or she will be isolated until no longer infectious to prevent the further spread of the disease. When an inmate refuses an x-ray, the physician will decide whether there is sufficient concern to transfer the person to the health-care centre for observation.

In response to the recent development of drug-resistant strains of tuberculosis, CSC decided to annually retest inmates who have previously tested negative on Mantoux testing.[52] This will allow "identification of persons who may have had contact with the disease and are at significant risk of developing it and infecting others."[422] This policy was supported by the Laboratory Centre for Disease Control of Health Canada.[423][53]

In 1992 four new cases of TB were reported in federal penitentiaries – three in the Ontario Region and one in the Quebec Region. In 1993, there were 20 new cases: six in the Quebec Region, ten in the Ontario Region, three in the Prairie Region, and one in the Pacific Region.[424]

In December 1992 active TB was diagnosed in an HIV-infected inmate housed in Drummond Institution. At the time of entry into prison, the inmate had refused both TB and HIV testing. The inmate later tested positive for antibodies to HIV. In December 1992 he was admitted to a community hospital where he was diagnosed as having active TB, HIV infection, and opportunistic infections. At Drummond Institution a plan of action was formulated: the institutional physician arranged for a local infectious-diseases specialist to speak to staff and inmates about TB; information meetings were held with union members and the institution's Health and Safety

[51] In this section the term TB is used to indicate infections with Mycobacterium tuberculosis and excludes other strains of mycobacteria.

[52] Some newspapers incorrectly reported that CSC was planning to immunize all inmates against tuberculosis.

[53] Policies concerning TB have also been adopted by some of the provincial prison systems. See, e.g., the directive of the Alberta Solicitor General, Correctional Services Division, Section: Health Services, Number: 20.15.05 of 5 June 1990. According to this directive, TB testing "shall normally be administered only to offenders that fall into identified high risk groups, however centres retain discretion to conduct TB tests in a more generalized manner."

Committee as well as the Inmate Committee; a video was prepared by the Chief of Health Care and by the Inmate Committee and broadcast periodically over the internal closedcircuit television system; an information bulletin was prepared and distributed to each employee of the institution; and staff and inmates were screened to determine if any were infected with TB.

THE DEBATE

Tuberculosis has featured in news headlines in Canada for the first time in decades. A curable disease has once again emerged as a public health threat in the developed world. The resurgence of TB in the United States, attributable in great part to the HIV epidemic and the social conditions that give rise to the spread of TB, and the emergence of multiple-drug-resistant strains of tuberculosis (MDR-TB), has created increasing concern in Canada. Recently, outbreaks of MDR-TB have occurred in the United States in occupational settings such as hospitals and prisons, with serious consequences for HIV-infected persons and for health-care workers. It has been said:

> In many areas of the United States the battle against tuberculosis is being lost. Two major markers of this failure are the increasing incidence of tuberculosis and the rising prevalence of drug-resistant tuberculous infection. The recent epidemic of multidrug-resistant tuberculosis in several East Coast hospitals and an explosive outbreak in the New York state prison system have taken well in excess of 100 lives. Since 1985, after 35 years of steadily declining incidence (with declines averaging 6 percent per year), tuberculosis case rates have increased each year. Direct and indirect epidemiological data indicate that the human immunodeficiency virus (HIV) has had a dominant role in this resurgence. In 1990, there were 25,701 new cases of tuberculosis reported in the United States – 9,883 more cases than anticipated on the basis of earlier trends.[425]

As stated by Bayer et al., the emergence of MDR-TB in the United States is fundamentally a reflection of failed social policy:

> If the resurgence of reactivation tuberculosis can largely be traced to the concurrent epidemic of HIV infection and the social conditions that give rise to the spread of tuberculosis infection, the emergence of resistant strains fundamentally reflects a failure of social policy. ...
>
> The congregate sheltering of large numbers of homeless individuals, hyperincarceration in jails and prisons have exacerbated the problem: the microbacterium spreads most efficiently in confined environments where there are large numbers of highly susceptible persons with compromised immune systems, including those with HIV infection. [with many references][426]

Dr. Hiroshi Nakajima, WHO's Director-General, stated that "[m]ore and more, tuberculosis is becoming a socioeconomic disease that hits the underprivileged hardest in both developed and developing countries."[427]

In many countries in Western Europe, like in the United States, TB incidence is increasing or levelling off from decade-long decreases.[428]

Neither TB nor MDR-TB appear as yet to be a major problem in Canada. Of the 1,996 TB cases reported in Canada in 1990, only 63 involved resistant organisms. Of these, only one was found to be resistant to four or more drugs.[429][54] Nevertheless, it has been said that "[although there is currently no information to suggest that the interaction between tuberculosis and HIV is a major problem in Canada, many of the conditions that favoured this interaction in the United States exist here."[430] Further, in both countries "[t]here

[54] However, data on drug resistance were unknown for 648 of the reported cases.

are population groups that are at risk for both HIV and TB; both diseases converge in hospital settings, prisons, and other public institutions, in ways that may favour transmission of TB among HIV infected persons."[431]

With regard to TB in prisons, Tomaševski stated that "[t]he publicity for AIDS has diverted attention from 'traditional' communicable diseases, such as tuberculosis, which is far from eradicated."[432] Recent reports from the United States have drawn attention to the dramatic increase in the incidence of TB in New York's state prison system – from 15.4 per 100,000 between 1976 and 1978 to 105.5 per 100,000 in 1986.[433] In New Jersey during 1987 the incidence of TB among state inmates was 109.9 per 100,000 – a rate 11 times that of the general population of New Jersey that year.[434] So severe is the increase in New York's TB caseload, especially among HIV-positive persons, that a federal judge ordered that a special unit for city jail inmates with TB be constructed. According to a report in the 10 February 1992 issue of American Medical News, New York corrections officials reported that 12 inmates, all with AIDS, died of TB in 1991. It was estimated that 26 percent of the female and 16 percent of the male inmates at New York's Rikers Island jail are HIV-positive, while 15 to 25 percent of all inmates test positive for past TB infection.[435] A recent study concluded that "[t]he demonstrated association between jail time or jail admissions and development of tuberculosis suggests that the New York City Jail system may be an important amplification point in the ongoing tuberculosis epidemic, deserving significant public health attention."[436]

Harding and Schaller drew attention to the fact that an increasing incidence of active pulmonary tuberculosis among HIV-infected prisoners has also been confirmed in prisons in France, Spain and Switzerland.[437] They concluded that, "[i]n view of prison conditions – a closed environment with frequent overcrowding and lack of ventilation – the problem of infectious tuberculosis requires special attention."

In his submission to ECAP, Ron Shore, formerly a prison outreach worker with the Kingston AIDS Project, pointed out that there have already been cases of TB in Toronto detention centres and in federal prisons and that it is only a matter of time before the disease becomes a plague. Unlike HIV, which requires intimate contact, TB can be transmitted through the air, via coughs and sneezes, so that in a prison setting it could become "wildfire death."[438]

In the United States, both the National Commission for Correctional Health Care and the Centers for Disease Control (CDC) have called for increased prevention and control efforts in prisons.[439] The United States Advisory Committee for the Elimination of Tuberculosis concluded that "[t]ransmission of TB in correctional facilities presents a health problem for the institutions and may also be a problem for the community into which inmates are released."[440] The Committee made a series of recommendations regarding control of TB in prisons:

> Each correctional institution should designate an appropriately trained official responsible for operating a TB prevention and control program in the institution. A multi-institutional system should have a qualified official and unit to oversee TB-control activities throughout the system. These responsibilities should be specified in the official's job performance plan. The basic activities to be followed are surveillance, containment, and assessment.

The Committee further recommended, among other things, that skin testing of inmates and staff should be carried out at entry or on employment, respectively, and that tests should be repeated at least annually; that inmates with TB should be routinely offered testing with appropriate counselling for HIV infection; that all inmates and staff with positive tuberculin reactions who have not previously completed an adequate course of preventive therapy be considered for preventive therapy unless there are medical contraindications; and that persons for whom TB preventive therapy is recommended but who refuse or are unable to complete a recommended course should be

counselled to seek prompt medical attention if they develop signs or symptoms suggestive of TB. These recommendations will be periodically revised.

The World Health Organization issued the following guidelines on TB in prisons:

41. The prison environment is often conducive to tuberculosis transmission and rates may be higher than in the general population. Furthermore, tuberculosis is increasingly associated with HIV/AIDS, so that the presence of HIV-infected prisoners may increase the risks related to the environment (e.g., by improving ventilation, reducing overcrowding, and providing adequate nutrition); to detect cases of tuberculosis as early as possible through screening for tuberculosis on entry and at regular intervals during imprisonment, and through contact tracing; and to provide effective treatment.

42. Diagnostic screening for tuberculosis in prison staff should also be available. Treatment programmes for prisoners with tuberculosis should be available in prisons, and adequate follow-up should be ensured when treated prisoners are transferred or released.

43. Epidemiological surveillance of tuberculosis among prison inmates and prison personnel is needed. Special attention should be paid to the early detection of outbreaks of drug-resistant tuberculosis and their control by public health measures. In particular, strategies should be implemented to ensure that prisoners complete tuberculosis treatment regimens.[441]

Respondents to ECAP's *Working Paper* generally agreed with the Committee's conclusion that the issue of TB in federal correctional institutions should be monitored closely by CSC. The Chairman of the Canadian Thoracic Society Tuberculosis Committee, Dr. Fitzgerald, and some of its members reviewed the section on TB in the *Working Paper.* The Tuberculosis Committee offered to establish a protocol for screening for TB and to liaise with CSC in its implementation. It was further suggested that ECAP consider whether "two-step tuberculin testing" should be the norm for both inmates and staff in correctional institutions, since studies have shown that individuals who have been infected by TB in the remote past or who have been BCG vaccinated may have a negative tuberculin test at the time of random testing.[442]

ECAP'S ASSESSMENT

ECAP is concerned about the recent resurgence of TB in prisons in the United States, particularly in view of its disproportional incidence among and impact on HIV-infected prisoners. The Committee commends CSC for its policy to control the spread of TB in federal correctional facilities and, in general, for taking the emerging issue of TB in prisons seriously. CSC should continue to closely monitor the situation with regard to TB in its institutions, and review its TB policy on a regular basis with the assistance of outside groups such as the Canadian Thoracic Society's Tuberculosis Committee.

RECOMMENDATIONS

9. The Committee recommends that the issue of tuberculosis in federal correctional institutions be monitored closely by CSC, in particular by its Health Care Services Branch and the Health Care Advisory Committee, and that CSC's policy with regard to tuberculosis be reviewed regularly.

10. PRISON HEALTH SERVICES

While the suggestions and recommendations made in section 8 address some of the immediate needs of infected inmates, this section addresses an underlying problem, namely inmates' distrust with regard to prison health-care services.

CURRENT SITUATION

In the federal prison system, as in most other prison systems, health-care services are an integral part of, and those who provide them are responsible to, the prison system. Support staff and nurses are employees of CSC, physicians contract their services to CSC, and services are generally located in the institutions. In addition, federal inmates are excluded by the *Canada Health Act*[443] from free medical coverage under provincial health-care plans.

THE DEBATE

Harding has emphasized how important prisoners' confidence in the independence, integrity and competence of the medical service is, especially in dealing with highly charged issues such as HIV infection.[444] He concluded:

> It is therefore in the prison administration's interest to accept, and even encourage, the independence of medical services and their strict observance of ethical rules. The underlying principle is that of equivalence. The prison doctor faced with an ethical dilemma should ask himself/herself: what would I do in the equivalent situation outside the prison? The same rules and principles should apply, whether in the face of a prolonged fast, the administration of tranquillizers to an agitated person, body searching, examinations requested by the authorities, the communication of medical information or free and confidential access of prisoners to health staff.[445]

In practice, prison health services are often perceived by prisoners to lack independence and confidentiality. Michael Linhart, a federal inmate with HIV infection, said:

> Any prisoner who has served a few years in a prison will tell you that health care is a primary concern among prisoners. We need to feel that we are being provided with competent and knowledgeable medical services. Often in prescribing medications to prisoners, doctors seem to follow a set of administrative procedures and policies outlining the types of medications given to prisoners. I know of many cases where doctors were about to prescribe a medication for a prisoner only to be told by the nurse in attendance that inmates are not allowed to have that drug in this institution. To myself, and many other prisoners, this seems to indicate that institutional policy is dictating to the doctor the type of medical attention they may render.[446]

The separation of prison health services from community health services, which underlies inmates' lack of confidence, is increasingly being challenged.[447]

Under the current system, the duties and responsibilities of prison health professionals go beyond providing medical services to inmates. The multiplicity of tasks that the prison health service has to perform, and the consequent difficulties in reconciling these tasks, has been well described by Leena Arpo, Chief Medical Officer of the Finnish Prison Administration:

> We may be accused of having become an integral part of the correctional machinery, who expend more energy on discovering malingerers than on treating sick patients, and who prescribe tranquillizing and hypnotic drugs in order to keep disruptive prisoners content and the prison nice and quiet. On the other hand, when the mass media report with sensational headlines of serious crimes committed by ex-convicts, we may be blamed for endlessly understanding and explaining the behaviour of the criminals, for doing nothing but letting them out to continue disturbing decent, respectable people. And inside the prisons, we may be accused by our fellow workers of putting too many prisoners on the sick list and thus endangering the productivity of prison industry.[448]

As stated by Tomaševski, existing international standards combine the provision of medical services with custodial duties, and continue

burdening prison health personnel with too many tasks, which often conflict with each other.

> Protecting the health of prisoners and participating in decision-making on their disciplinary punishment are proverbially difficult to reconcile, and illustrate the difficulties inherent in giving the same institution and the same personnel three distinct responsibilities: custody, punishment, and care.[449]

That problems are created by organizing prison health services outside the ordinary health system has been acknowledged by the Select Committee of Experts on the Impact of the AIDS Epidemic on Health Care Services and Planning in Europe.[450] A variety of solutions to these problems were proposed, including recourse to ordinary health services such as intervention by outside staff in prisons and early treatment outside prison.[451]

In 13 provincial institutions in Quebec, health care is already provided, at least in part, by outside community clinics or hospital centres,[452] and in Norway health services for the prison population have been fully integrated into the national health-care system. In these settings the principle of equivalence has been fully implemented, and all health services are provided by community health services. In most other prison systems, access to community health services for inmates is restricted:

> [Inmates'] access to the community medical facilities is limited by the degree to which such facilities can provide secure accommodation and are willing to take on the responsibility for the security of inmate patients. Effectively, prisoners' access to outside services and facilities is determined by the decision of the prison health service, or the prison administration, and is often discretionary. The most frequent practice is the referral by the prison physician to the community health care service where and when s/he deems it necessary.[453]

In an article that recently appeared in *Le Monde diplomatique*, it was stated that HIV/AIDS would force prison administrations to transfer the costly and over-burdened prison health-care services to the community:

[Translation]

> How, for example, are prison administrations going to deal with the forecast increase in the number of inmates who require intensive medical care when their health budget is already inadequate to meet the needs of a highly disadvantaged population? The impossibility of successfully managing the AIDS budget of prisons is without doubt the deciding factor in the need to transfer an archaic system of prison health management by prison administrations alone to a system of management by the public health-care system....[454]

In Canada, the Parliamentary Ad Hoc Committee on AIDS recommended that the advantages of prison health-care services being provided by outside agencies should be further studied.[455]

In France, the National Commission on AIDS [TRANSLATION] "considers it urgent and necessary, to facilitate the work of health-care personnel and to do away with the ambiguities surrounding their duties and responsibilities, that public authorities succeed in placing prison health services and health-care personnel working in a prison setting under the exclusive administrative and financial control of the Ministry of Health."[456]

Few respondents to ECAP's *Working Paper* commented on the issue of whether prison health services should be provided by outside agencies, but responses generally agreed with the Committee's conclusion. For example, one inmate stated:

> I believe that health service would be more effective if provided by an external agency. Regrettably, any person working under a contract for the C.S.C. is provided with powers which inmates often feel make them "part of the system." This means that some inmates would still be reluctant to deal openly with the

> contract staff. Even given this we believe that in general many of the current complaints regarding health care would be significantly reduced were the institutions to change to an outside agency contract plan.[457]

The Canadian AIDS Society's response "presses for action on the issue of using outside health services," and PASAN stated it would have preferred "a direct recommendation on the issue of outside services and supported this action because of the obvious benefits re testing, counselling and care."

ECAP'S ASSESSMENT

ECAP commends CSC for its efforts to provide health care that is equivalent to that outside prison. However, ECAP is concerned that some inmates, in particular HIV-infected inmates, do not utilize these services because they perceive them to lack independence and are afraid that their medical information will not be held confidential. ECAP is aware that separating CSC's health-care services from CSC and integrating them into the provincial health-care systems raises many problems that the Committee could not address. Because this is an important issue that needs to be studied in detail, the Committee concluded that the issue should be brought to the attention of CSC, and in particular its Health Care Advisory Committee, for further study.

RECOMMENDATIONS

10. ECAP recommends that CSC, and in particular its Health Care Advisory Committee, study the feasibility of prison health-care services being provided by outside agencies.

11. COMPASSIONATE RELEASE

CURRENT SITUATION

In 1989 the National Parole Board (NPB) initiated an examination of its conditional-release policies with regard to HIV-infected offenders, in response to requests for guidance from Board members who were having to confront the issue of conditional release of inmates with HIV infection or AIDS. In general, the primary objective of NPB decision-making is to contribute to the protection of society through the assessment and management of the risk that offenders represent when released into the community. Risk has traditionally been interpreted as the risk that a released offender may re-offend. As stated by Mr. Gibson, then Chairman of the NPB,

> [i]n examining the issue of AIDS and conditional release, the Board sought to determine if, during its deliberations on a case, it should take into consideration the offender's medical condition, which is known to the Board, together with his/her social attitude, when it might constitute a risk to society.[458]

The Board hosted a one-day seminar on 23 March 1989 at which a variety of experts from different backgrounds provided an overview of the legal, medical and ethical issues "and assisted the Board in focusing its review on those issues that affect re-integration decisions."[459] Following the meeting, a policy on Acquired Immunodeficiency Syndrome (AIDS) and Conditional Release Decisions was issued and became effective on 1 May 1991. In developing the policy, NPB was guided by the *Parole Act*, the Board's mission statement, decision policies and evolving government policy. In particular, "[t]he Board sought to reflect the concerns which were expressed by the participants at the seminar and others who were consulted."[460]

The purpose of this policy is "[t]o provide guidance to Board Members in making conditional release decisions in cases where an offender has tested positive to the HIV virus, and therefore may or may not have developed AIDS." The policy focuses on risk assessment and the reintegration potential of the offender while attempting to be responsive to the special needs of offenders infected with HIV. In turn, risk assessment focuses on the previous behaviour or documented

expressions of intent by the offender, and not on HIV status alone. HIV status will be a factor for consideration in decision-making only when parole by exception for humanitarian reasons is proposed. The policy reads as follows:

> HIV status in and of itself is not a factor in risk assessment or decision making. In its risk assessment and decision making, NPB will not require information on whether or not an inmate tests HIV antibody positive.
>
> The Board is committed to giving full consideration to applications for release, including parole by exception, where necessary in order to ensure medical treatment or palliative care not otherwise available within the institution. The Board is sensitive to humanitarian considerations with respect to all terminally ill offenders. Considerations for release must always take place within the context of the risk to society.
>
> The Board will consider in its risk assessment evidence of behaviour or expressed intent which demonstrates wanton disregard for public safety and which may cause loss of life or serious harm, such as through HIV transmission, and may use such evidence in reaching its decision.
>
> The Board is committed to ensuring that training and education in the understanding of the medical and social dimensions of HIV infection is available to Board members and staff.

With regard to eligibility for parole in so-called exceptional cases, s. 121 of the *Corrections and Conditional Release Act* provides as follows:

> (1) Subject to section 102 and notwithstanding section 119 or 120 or any order made under section 741.2 of the *Criminal Code*, parole may be granted at any time to an offender
>
> (a) who is terminally ill;
>
> (b) whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement;
>
> (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; or
>
> (d) who is the subject of an order to be surrendered under the *Extradition Act* or the *Fugitive Offenders Act* and to be detained until surrendered.
>
> (2) Subsection (1) does not apply to an offender who is
>
> (a) serving a sentence of life imprisonment imposed as a minimum punishment or commuted from a sentence of death; or
>
> (b) serving, in a penitentiary, a sentence of detention for an indeterminate period.

Section 121(1)(a)-(c) is nearly identical to section 11.1(1)(a)-(c) of the *Parole Regulations* that it replaces. Under section 11.1 of these *Regulations*, "Parole by Exception" could be granted to inmates who were not otherwise eligible for parole under the same circumstances that are now specified in the *Corrections and Conditional Release Act*. Other than temporary absences, parole by exception and executive clemency are the only forms of release that formally permit the consideration of humanitarian concerns such as those that could arise in cases of inmates with HIV infection or AIDS. The procedure is only used in rare cases,[461] and all the other criteria for the granting of parole – particularly that the inmate not be an undue risk to society – must also be fulfilled for a grant of parole by exception.[462]

THE DEBATE

The current system and practice of granting parole by exception has been criticized by PASAN on the basis that compassionate release is currently only

considered for terminally ill prisoners whose sickness is so advanced that they are near death, and that release at such a point means little else than a transfer from one form of institution to another – from the prison to a hospital. It therefore suggested that new guidelines be developed to allow for early parole and probation for medical reasons, and concluded that, if possible, prisoners living with HIV/AIDS should be released from the penal system as early into their sentences as possible, subject to security concerns, because living with HIV infection requires a positive and healing environment.[463]

Similarly, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that consideration be given to "compassionate early release" for inmates with AIDS.[464]

In the United States, the National Prison Project stressed the need to develop compassionate early-release programs for prisoners with AIDS because prison medical centers and hospitals "are not equipped to deal with the complexities of the AIDS virus. When prisoners are ill with AIDS, assuming they have a place to go on the outside – hospices, family, etc. – there should be a procedure for their release. Right now most medical clemency programs both in the federal and state systems are too slow moving to be effective. By the time the prisoner gets processed through the prison bureaucracy, he or she is dead or near death."[465]

The [U.S.] National Commission on AIDS stated "that there also needs to be in place in every corrections system a responsive mechanism for the early release of all terminally ill prisoners, including those with HIV disease, who no longer pose a danger to society and whose further incarceration would serve no purpose."[466] In particular, the Commission encouraged the Federal Bureau of Prisons as well as states and localities to review the early-release options available so that incarceration for persons with HIV disease is not a death sentence. The Commission recommended that "[m]echanisms for early release should be streamlined and made readily available for prisoners who are seriously ill and whose release would be unlikely to pose a danger to society."[467]

The World Health Organization's *Guidelines on HIV Infection and AIDS in Prisons* contain the following provisions with regard to early release of prisoners with AIDS:

51. If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom.

52. Prison medical services should provide full information on such prisoners' health status, treatment needs and prognosis, if requested by the prisoner, to the authorities competent to decide upon early release. The needs of those prisoners without resources in the community should be taken into account in any early release decision.[468]

Without exception, respondents to ECAP's *Working Paper* agreed with the Committee's conclusion on compassionate release.

ECAP'S ASSESSMENT

Concern was voiced to ECAP that inmates with AIDS are often released from institutions only shortly before their death. In practice, this means a release from prison to a hospital or hospice.

ECAP concluded that, whenever possible, inmates with progressive life-threatening diseases should be released earlier in the course of their disease. ECAP recognizes that imprisonment can be more detrimental to the health of a person with HIV or AIDS than to the health of prisoners whose immune systems are not compromised. Generally, life in prison for inmates with a chronic or progressive fatal disease is more psychologically stressful and more physically detrimental than for inmates who are healthy. This is particularly true

for inmates with HIV infection or AIDS. Among the reasons for this are: exposure to infections that might otherwise be avoidable; reduced access to support and counselling from community-based organizations, friends, partners and family; potential delays in access to specialists, special diets and new or experimental treatments; and discrimination. A 1986 study by the New York State Commission on Correction showed that prisoners with AIDS lived only half as long as people with AIDS outside prisons.[469] Although the results of this study are not necessarily applicable to Canadian penitentiaries, they nevertheless indicate the potentially serious consequences of imprisonment for people with HIV infection or AIDS.

ECAP acknowledges that protection of the public has to remain the paramount consideration in all decisions relating to the release of inmates, including inmates with HIV infection or AIDS. Within this limit, however, ECAP considers that protection of inmates' physical and mental health should be given greater consideration in such decisions. Inmates with AIDS should be granted parole by exception or, in the case of inmates serving an indeterminate sentence, executive clemency before they are terminally ill, whenever they do not constitute a threat to the public. This approach should also apply to any inmate with a chronic or progressive life-threatening disease whose health is likely to suffer if the inmate continues to be held in confinement. This approach would not necessitate changes in the provisions of the *Corrections and Conditional Release Act* or in NPB's policy. However, in practice it should lead to more frequent granting of parole by exception or executive clemency to inmates with progressive life-threatening diseases.

RECOMMENDATIONS

11. **ECAP recommends that inmates with progressive life-threatening diseases, including AIDS, regularly be released earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety.**

12. AFTERCARE

CURRENT SITUATION

At present, the only specific provision relating to the continuation of care and support of inmates with HIV infection or AIDS after their release into the community is s. 20 of Commissioner's Directive 821, which reads as follows:

> 20. Upon transfer to parole jurisdiction, health care staff shall, with the inmate's consent, ensure that arrangements have been made for follow-up with an appropriately qualified community physician.

In the revised version of this Directive (approval pending), this section remains unchanged.

THE DEBATE

PASAN stated that, to ensure the success of CSC's efforts to provide services and care for inmates with HIV infection or AIDS, "mechanisms must be implemented to ensure that these programs can be continued upon a prisoner's release."[470] In particular, it recommended that: parole officers, probation officers, workers in halfway houses and other aftercare workers be educated about HIV/AIDS; exit kits containing HIV/AIDS information, contacts with community-based organizations, condoms, bleach kits, etc. be made available to prisoners when they are released from correctional facilities; programs providing continuity of care after release be established for prisoners with HIV/AIDS; any special programs used by a prisoner with HIV/AIDS remain available to her or him outside of prison; community-based groups be involved in the development and implementation of aftercare strategies; the Ministry of Correctional Services and CSC work with community-based HIV/AIDS housing programs and service organizations to ensure that they meet the needs of ex-prisoners.[471]

In the United States, the National Commission on AIDS emphasized that "[c]areful planning for the discharge of prisoners living with HIV disease is a critical aspect of their care"[472] and recommended that "[t]o maintain continuity of care during the transition from prison to the community, every inmate with HIV disease should be assisted in finding medical care and support services in the community."[473] The Commission continued by saying that "[t]his should include assisting prisoners to register with community based case management services prior to release where such services are available and if the prisoner so desires."

Discharge planning is an important component of the HIV policy proposed to the District of Columbia Department of Corrections by the D.C. Prisoners Legal Services Project.[474] According to this policy, discharge planning includes, among other things: (1) providing all prisoners, regardless of HIV status, with counselling and written HIV educational materials about community resources, including referrals for medical care, drug use treatment, and social and legal support services; (2) providing prisoners with condoms and dental dams upon release into the community or to a halfway house; (3) preparation by medical staff, for each prisoner with HIV or AIDS, of a so-called "discharge packet" containing information about the prisoner's current diagnoses and medical/mental health problems; current treatments and treatment history, including laboratory test results and complete medical, dental, and mental health records; HIV-related medical complications, including full documentation for any HIV-related opportunistic infections; allergies; description of conditions on discharge; and follow-up instructions. If the prisoner provides appropriate authorization, the medical staff will send a copy of the prisoner's complete discharge packet to the prisoner's outside care provider; (4) an exit interview for HIV-positive prisoners at which medical staff will provide referrals for health care, drug treatment, and psychosocial support service providers in the community where the prisoner is to be released. If the prisoner does not already have an outside primary medical care provider, medical staff will help the prisoner select one; (5) arranging an initial medical consultation in the community and notifying prisoners of the time and place of the consultation where prisoners' medical condition renders them unable to participate in medical discharge planning; (6) efforts to contact the prisoner's family or other designated persons to assist in the discharge planning process, if the prisoner authorizes the release of HIV-related information. Families will be offered education and counselling on HIV/AIDS to help them understand the prisoner's needs and to allay any fears they may have about HIV transmission.[475]

The French National Commission on AIDS has recently emphasized that [TRANSLATION] "ensuring care of and follow-up for prisoners upon release seems essential. As the Council of Europe noted in a recent report, "the important thing is to ensure that the prison population receives, upon their return to normal life, the preventive and other care that began in prison."[476] ... . While it recognizes the difficulties of follow-up on the outside and of preparing releases, the Council would like to see specific actions undertaken to prepare releases."[477]

Respondents to ECAP's *Working Paper* expressed agreement with the Committee's conclusions on aftercare.

ECAP'S ASSESSMENT

ECAP commends CSC for its efforts to assist inmates with HIV infection or AIDS to build links with outside support and service organizations. Sometimes, however, inmates have had difficulty with the continuity of their care after their release from federal correctional facilities.

ECAP considers that, in order to ensure the success of CSC programs for inmates with HIV infection or AIDS, it will be important to increase efforts to provide inmates with continuity of care and support.

RECOMMENDATIONS

12. **ECAP considers that inmates with HIV infection or AIDS should have the opportunity and be encouraged to maintain or build links with the outside world, in particular with HIV/AIDS service, support and health organizations. In order to ensure this, ECAP recommends the following:**

    (1) Parole and probation officers, workers in halfway houses, and other aftercare workers should receive educational sessions about HIV/AIDS, in particular concerning the needs of and the community resources for people with HIV infection or AIDS.

    (2) A "health kit" should be offered to every inmate on exit from a correctional institution, along with information about available community resources.

    (3) CSC should continue to assist inmates who require ongoing medical care to organize this care before they are released.

    (4) Inmates should be encouraged to arrange for the transfer of their medical records to their future care providers.

    (5) External, community-based AIDS, health or prisoner organizations that provide services and education to people with HIV infection or AIDS should be encouraged to provide such services in federal correctional institutions so that, prior to their release into the community, inmates can establish links with these organizations.

13. WOMEN INMATES

CURRENT SITUATION

In 1992 there were only 313 women inmates (2.1 percent) in the federal on-register offender population.[55] Many of them serve their sentence in the Prison for Women in Kingston, the only federal correctional facility for women. Others serve their sentence in provincial facilities under federal-provincial exchange-of-services agreements. The number of federally sentenced women with HIV infection or AIDS is unknown. However, the seroprevalence studies undertaken in a provincial medium-security prison for women in Montreal[478] and the study of HIV prevalence in provincial adult correctional facilities in British Columbia,[479] as well as a series of studies undertaken in prison systems in other countries, have shown that HIV infection is prevalent among women prisoners, in particular among those who have a history of injection drug use. As the following data illustrate, HIV seroprevalence among women prisoners generally exceeds that of male prisoners:[480]

	Women	Men
Montreal	7.2%	3.6%
British Columbia	3.1%	0.9%
Brazil (Sao Paolo)	28.7%	20.0%
England	15.0%	7.7%
Ivory Coast	23.0%	18.0%

Among prison entrants in the United States, HIV seroprevalence rates are also generally higher for women than for men.[481] The US National Commission on AIDS reported that in New York State the seroprevalence rate for female entrants was 18.8 percent compared to a rate of 17.4 percent among male entrants.[482] The Commission further reported that preliminary results from a study of 1,000 consecutive entrants in each of ten

[55] The on-register population includes federal offenders incarcerated in provincial institutions and provincial offenders incarcerated in federal institutions under federal/provincial exchange-of-services agreements. It includes offenders on federal day parole. Offender Population Profile System. Management Information Services, CSC, 31 March 1991.

different correctional systems throughout the United States indicated that in general HIV prevalence rates were higher among female than among male entrants. Data were available for offenders entering prisons as well as for offenders entering jails. The seroprevalence rates among male offenders entering the prison systems ranged from 2.1 to 5.9 percent, while among female offenders they ranged from 3.2 to 7.8 percent. Among male offenders entering the jail systems the rates ranged from 2.3 to 7.6 percent, and among female offenders they ranged from 2.5 to 14.7 percent.[483]

With regard to female offenders, s. 77 of the *Corrections and Conditional Release Act* states that CSC shall

(a) provide programs designed particularly to address the needs of female offenders; and

(b) consult regularly about programs for female offenders with

(i) appropriate women's groups, and

(ii) other appropriate persons and groups with expertise on, and experience in working with, female offenders.

THE DEBATE

> Like every other epidemic, AIDS develops in the cracks and crevasses [sic] of society's inequalities. We cannot face the epidemic if we try to hide the contradictions and conflicts which it exposes.[484]

Underlying many of the problems that women in prison encounter is that "[t]he majority of women in prisons are members of social groups marginalized not only on the basis of gender, but also on the basis of race, class, sexual orientation, disability, substance use, and/or occupations as sex workers."[485] Female inmates often have more health problems than male inmates. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care. Within our society, women have traditionally been the caregivers, often subordinating their own health and well-being to that of others.[486] Women are often deprived of the power to determine the conditions upon which their sexual relationships with men take place: "For many women, sexual intercourse is not a question of choice but rather a question of survival."[487]

Many HIV-infected women do not receive the diagnostic and treatment services that could benefit them as early as do HIV-infected men. Among the reasons for this is that women are often unaware of having been exposed to HIV by their sexual or drug-using partners and as a result do not seek counselling, HIV testing, and care and treatment. Second, the needs of HIV-infected women differ from those of men, and social and community support are often less frequently available and less accessible. As a consequence, women are often less educated than men about HIV infection and AIDS and do not have the support structures they need. Third, disease manifestations attributable to HIV infection or AIDS are often different in women than in men, leading to underrecognition or delays in diagnosis. Thus, women who are infected are often diagnosed as infected or having AIDS later than men, are deprived of the potential benefits of early detection of HIV infection and its treatment, and often have advanced disease when their infection is diagnosed.[56]

For all these reasons, "[t]he educational needs of women prisoners regarding AIDS are different from the needs of male prisoners" and "the need for HIV prevention programs in women's prisons may be even more pressing than in male prisons."[488]

[56] In an effort to improve this situation, the medical community is reviewing criteria for diagnosis of AIDS, in particular as it relates to women, and international and national organizations have called for increased educational, support, diagnostic and treatment services for women who are infected with HIV or who have AIDS.

PASAN recommended a variety of measures to address women prisoners' needs with regard to HIV/AIDS: (1) Education and prevention information should be culturally sensitive and gender specific, and pamphlets, posters, videos, speakers and counsellors should target readers and audiences with diverse cultural backgrounds and literacy skills. There should be information about pregnant HIV-positive women and HIV-positive mothers with both HIV-positive and HIV-negative children. (2) A broad range of prevention materials targeted specifically to women should be made available in ways that would protect prisoners' confidentiality. These include dental dams, condoms, thin latex gloves, water-soluble lubricants, bleach kits, and clean needles. (3) Women with HIV/AIDS should have access to appropriate treatments and hospital care. Current levels of medical care and expertise within the prison system are often insufficient to meet the needs of women living with HIV/AIDS. Women should have HIV primary-care physicians who are knowledgeable about women's symptoms, and should be free to choose the physician they believe is appropriate for their needs. (4) Women with HIV/AIDS should have access to 'outside' resources such as female counsellors and facilitators who are culturally and ethnically appropriate. Not only can community-based AIDS workers support women prisoners living with HIV/AIDS, they can assist in the development of peer support groups within and outside the prison.[489]

A proposal for a Women's Health Education and Support Program was submitted to ECAP by Tracy Brownlee, formerly with the Prison Health Program of the Kingston AIDS Project. The proposed program is intended to encourage the promotion of self-care and wellness among women prisoners, and to increase the level of choice, self-esteem and control that women possess, in order to maximize their own welfare. This would be done by addressing the larger issues women face and by including a broad definition of health and well-being. Issues of physical (e.g., HIV and AIDS), mental (e.g., drug use), emotional (e.g., depression and abuse) and spiritual (e.g., wellness and self-esteem) health would be addressed. Prevention of illness, stress reduction, mental, spiritual and emotional health, and physical self-care would be given equal attention. The women would also be provided an opportunity to share and learn effective coping skills for dealing with stress, trauma and the various risks to their health.[490]

In the United States, the National Commission on AIDS stated that "[i]ncarcerated women have been, and continue to be, a forgotten population."[491] The Commission concluded that urgent attention needed to be given to the special needs of female inmates, and made the following statement:

> In addition to the services available to their male counterparts, women in prison are in desperate need of HIV education regarding perinatal transmission and pediatric AIDS, frequent pap smears and other services sensitive to gender and the distinct history of female inmates regarding the conditions of their confinement. In addition, pregnant inmates are in need of prenatal services where HIV testing is offered upon request. Special care to provide education and counselling in a context of freely available reproductive choice is essential.[492]

In some prison systems, programs to address the particular needs of women inmates with regard to HIV/AIDS have already been developed. For example, at a provincial medium-security prison for women in Montreal, community input into information and prevention efforts started as early as 1987, after the first case of an HIV-infected woman in that prison became known. These efforts have included education about HIV/AIDS for both staff and prisoners, access to anonymous HIV testing carried out by outside community-health clinics, and cooperation with external resources for medical and psychosocial support. Research on HIV seroprevalence and on risk factors among prisoners started in January of 1988. As a result of these efforts, a climate of tolerance replaced the initial reactions of fear and discrimination against HIV-infected prisoners.[493]

In New South Wales, prisoners' AIDS committees operate within prisons. Their function is to impart knowledge of HIV/AIDS prevention to prisoners. Methods used include group sessions, preparation and distribution of pamphlets and posters, plays, video script writing, and musical compositions. An AIDS education officer from outside prison facilitates the committees' work with up-to-date information. Liaising with prison staff and superintendents about committee activities keeps communication channels open.[494]

At several prisons for women in the United States, peer education programs have been developed. Among these is PLACE (Pleasanton AIDS Counseling and Education), which developed a project of self-education of women prisoners about HIV/AIDS. This project emphasizes self-empowerment: from the beginning, PLACE tried to make it *their* program – defined by women prisoners and their needs, and run by them. In their self-education phase, this meant each of them taking responsibility for a very basic presentation on various aspects of HIV/AIDS. This was not easy for many prisoners in the group, since most of them had never formally spoken in front of even small groups of people. They also had to confront deeper issues of empowerment and self-direction. The small steps of learning new information and presenting it to a group, or of figuring out goals and a program of HIV/AIDS education for sister prisoners, were "really giant steps in the process of empowerment, commitment, and enhancing our self-esteem."[495]

The World Health Organization's *Guidelines on HIV Infection and AIDS* emphasize that special attention should be given to the needs of women prisoners. They read as follows:

44. Special attention should be given to the needs of women prisoners. Staff dealing with detained women should be trained to deal with the psychosocial and medical problems associated with HIV infection in women.

45. Women prisoners, including those who are HIV-infected, should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to infant, or through sexual intercourse. Since women prisoners may engage in sexual intercourse during detention or release on parole, they should be enabled to protect themselves from HIV infection, e.g., through the provision of condoms and skills in negotiating safer sex. Counselling on family planning should also be available, if national legislation so provides. However, no pressure should be placed on women prisoners to terminate their pregnancies. Women should be able to care for their young children while in detention regardless of their HIV status.

46. The following should be available in all prisons holding women:

    - gynaecological consultations at regular intervals, with particular attention paid to the diagnosis and treatment of STDs
    - family planning counselling services oriented to women's needs
    - care during pregnancy in appropriate accommodation
    - care for children, including those born to HIV-infected mothers
    - condoms and other contraceptives during detention and prior to parole periods or release.[496]

Without exception, respondents to ECAP's *Working Paper* agreed with the Committee's conclusions relating to care and support of female inmates.

ECAP'S ASSESSMENT

ECAP met with inmates and staff at the Prison for Women in Kingston on 19 November 1992 in order to hear their views and suggestions on how to address issues relating to HIV/AIDS of particular relevance to women inmates.

ECAP acknowledges that the problems encountered by female inmates in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. The task of protecting women prisoners from HIV transmission therefore presents different – and sometimes greater – challenges than that of preventing HIV infection in male prisoners. At the same time, ECAP witnessed that women in prisons often offer each other more support and are more compassionate than many male prisoners. ECAP feels that the challenge is to address women's needs and concerns while building on their ability to be compassionate and to offer each other support. The Committee examined a variety of possible ways to achieve this, including:

- Education and prevention information specifically targeted at women inmates.

ECAP found that HIV education and prevention efforts in prison, as outside, seldom address the specific needs of women. Consequently, there is a need for educational and prevention programs for women. Among the issues that should be addressed in such programs are: pregnancy, contraception, HIV transmission from mother to child, safer sex activities, and women's health problems.

- Efforts directed at decreasing the vulnerability of women to abuse in general, and to HIV infection and drug use in particular.

ECAP concluded that prevention efforts must be designed that will enable women to protect themselves from exposure to HIV. With regard to HIV infection, persuading sexual partners to use condoms is often a difficulty for women. It is therefore essential to empower them to negotiate safer sex practices and to practice safe activities while in prison and to continue to carry them out upon release.[497] In a broader perspective, efforts are needed to increase women's self-esteem and to decrease their vulnerability to abuse in general.

- Promotion of community and peer input into information and prevention efforts.

ECAP considers that supporting and implementing peer education programs and programs provided by outside community groups will be essential. There are several models of this approach that are operational in prisons in Quebec, the United States and Australia. The proposal for a Women's Health Education and Support Program submitted to ECAP is another example of what might be implemented by CSC. Developing such programs would be consistent with, and in part is mandated by, s. 77 of the *Corrections and Conditional Release Act.*

RECOMMENDATIONS

13. ECAP recognizes the special needs and concerns of women inmates with regard to HIV infection and AIDS, and recommends the following:

(1) CSC should ensure that there are educational and prevention programs specifically targeted to women inmates, including information about pregnancy and HIV transmission from mother to child, women's health problems, and the risk of transmission of HIV and other infections from sexual activities.

(2) CSC should ensure that there are programs that will help to empower women inmates and decrease their vulnerability to abuse in general and to HIV infection and drug use in particular.

(3) CSC should ensure that community and peer input into these programs is provided.

(4) CSC should ensure that adequate counselling and support for pregnant inmates are available.

14. ABORIGINAL INMATES

CURRENT SITUATION

In prisons in Canada, Aboriginal inmates are overrepresented compared with the general inmate population. In 1991-92 they accounted for 10.8 percent of the male and 19.8 percent of the female federal inmate population. In some areas the percentage is much higher. For example, in the Prairie Region Aboriginal offenders accounted for 35.5 percent of the male and 55.3 percent of the female population.[498] They accounted for approximately 19 percent of all sentenced admissions to provincial institutions.[499] This proportion varies across Canada, but everywhere Aboriginal offenders are vastly overrepresented. For example, 6.6 percent of offenders admitted to institutions in Ontario are Aboriginals, whereas Aboriginals represent only two to three percent of the entire population of Ontario.[500]

Few data are available on levels of HIV infection among Aboriginal inmate populations. The initial seroepidemiological study undertaken by Hankins among women showed that Aboriginal women were overrepresented among participants in the study in comparison to their representation in the prison population as a whole, but none were HIV-positive.[501] In the study of HIV prevalence in provincial adult correctional facilities in British Columbia, none of the 47 Aboriginal women who were tested were found to be positive. However, seven Aboriginal women refused to be tested and results of the study must therefore be interpreted with caution.

The needs of Aboriginal offenders have been recognized in sections 79 through 84 of the *Corrections and Conditional Release Act*. In particular, sections 82 and 83 read as follows:

> 82. (1) The Service [CSC] shall establish a National Aboriginal Advisory Committee, and may establish regional and local aboriginal advisory committees, which shall provide advice to the Service on the provision of correctional services to aboriginal offenders.
>
> (2) For the purpose of carrying out their function under subsection (1), all committees shall consult regularly with aboriginal communities and other appropriate persons with knowledge of aboriginal matters.
>
> 83. (1) For greater certainty, aboriginal spirituality and aboriginal spiritual leaders and elders have the same status as other religions and other religious leaders.
>
> (2) The Service shall take all reasonable steps to make available to aboriginal inmates the services of an aboriginal spiritual leader or elder after consultation with
>
> (a) the National Aboriginal Advisory Committee mentioned in section 82; and
>
> (b) the appropriate regional and local aboriginal advisory committees, if such committees have been established pursuant to that section.

THE DEBATE

Issues relating to HIV/AIDS and Aboriginal inmate populations in Canada were studied by Trasher Consultants for the Joint National Committee on Aboriginal AIDS Education and Prevention in the fall of 1992. A Final Report on AIDS and Aboriginal Prison Populations was released in March 1993.[502] The purpose of the research was to "determine the nature and extent of the problem; examine what is currently being done to address the issues both for prevention and treatment of HIV positive inmates; assess the appropriateness of these efforts; set out the nature of unmet educational needs of Aboriginal offenders; outline ways to more adequately meet those needs within the prison and community supervision; and ensure that the proposed

initiatives are consistent with Aboriginal cultural values, beliefs and practices."

With regard to rates of infection among Aboriginal offenders, the Report cites one prison official who predicted that "if all Aboriginal inmates in prisons were tested the HIV rate would be high."[503] Some correctional staff, however, suggested low rates of HIV infection among Aboriginal inmate populations because "Aboriginal inmates tend to engage in sex in institutions less frequently than non-Aboriginal inmates" and because "the drug usage of Aboriginal offenders is typically related more to alcohol, pills and sniffing rather than intravenous drug use." The Report continues by saying that until a national unlinked seroprevalence survey is carried out in the prison population in Canada, it will be impossible to understand the extent of the problem of HIV/AIDS among Aboriginal and non-Aboriginal offenders. The Report therefore recommends that CSC "contract an independent medical organization to undertake anonymous unlinked seroprevalence testing in a sample of federal correctional institutions in the Prairie Region aimed at ascertaining the prevalence of HIV/AIDS in the entire prison population."[504,[57]]

The Report points out that there are no specific prison policies or procedures on HIV/AIDS pertaining to Aboriginal offenders. It then briefly reviews many of the issues raised by HIV/AIDS in correctional facilities. The following is an overview of some of its findings.[505]

With regard to injection drug use, the Report makes the point that the most serious problem facing Aboriginal inmates in terms of HIV/AIDS is the widespread sharing of potentially contaminated needles during injection drug use. In one federal institution Aboriginal inmates and senior correctional staff estimated that about 18 needles were used by about 30 inmates (out of a prison population of 249), while inmates suggested there were at least 40 needles in the institution. In any event, inmates are aware that needles cannot be properly cleaned between uses. The most frequently used method of cleaning needles is by using hot water, and in many cases injection equipment is shared with other Aboriginal inmates.

With regard to the availability of bleach, the Report indicates that in some institutions bleach is informally available to inmates in various locations, such as in the laundry and cleaning storage areas. Whenever possible, the bleach is used for cleaning the needles, but the practice is illegal and the cleaning of needles with bleach is therefore a hit-and-miss proposition at best, as inmates have to be constantly aware of the risk of getting caught and having the needle confiscated. Furthermore, the supply of bleach is not reliable.

The Report also states that virtually all those interviewed mentioned that another serious problem in terms of HIV/AIDS was the extensive tattooing that occurs in prisons among Aboriginal inmates. Tattooing is an integral part of Aboriginal inmate culture, performed by inmates skilled in the practice and using a variety of available instruments. Rarely are these instruments professional tattooing tools. Inmates reported that everything from broken glass to sharpened guitar strings is used for tattooing. The fact that tattooing is "illegal" in prisons accounts for the use of such diverse, and potentially unclean, tools.

The Report discusses whether and to what extent Aboriginal offenders constitute a "special needs group" with regard to HIV/AIDS and the issues raised by it.[506] It reports that most observers have suggested that, with the exception of educational programs, the issues were not different for Aboriginal offenders. However, two potential concerns were raised. The first relates to the impact HIV infected offenders might have if released into Aboriginal communities. There was a sense that irresponsible behaviour such as unprotected sex by an infected offender could be devastating to a small, relatively closed community, and some suggested that Aboriginal

[57] Penitentiaries in the Prairie Region were suggested because the percentage of Aboriginal inmates is highest in that region. Test results would therefore ensure a significant representation of Aboriginal inmates. The Report opposes carrying out "the testing with just Aboriginal inmates because if test results indicated a significant number of positive results Aboriginal offenders could be singled out for discrimination by non-Aboriginal inmates."

inmates should feel obliged to be tested for HIV antibodies to ensure that they were not a risk to their community. A second concern relates to the spread of TB among Aboriginal Peoples. It is estimated that there is a high prevalence of "inactive" TB in Aboriginal communities. If individuals became infected with HIV, their susceptibility to "active" TB would be increased, due to lowered immunity.[507]

The Report concluded that "[i]t is clear that there is no epidemic of HIV/AIDS among Aboriginal inmates," but that at the same time there may be three reasons for concern. First, there are now a number of cases confirmed among Aboriginal offenders. Second, the long period (two to ten years) during which no symptoms are evident makes it impossible to know if inmates are infectious. Third, inmates engage in high-risk activities (sexual activity, injection drug use, tattooing).[508]

The Report contains a variety of recommendations, many of which concern issues addressed in previous sections of the *Final Report*. With regard to issues of particular relevance to Aboriginal inmates, the following recommendations were made:

> That a senior official of Correctional Service of Canada be invited to become a member of the Joint National Committee on Aboriginal AIDS Education and Prevention with a view to establishing a comprehensive strategy to address the issues involved with HIV/AIDS among Aboriginal offenders in prisons.
>
> That the Joint National Committee on Aboriginal AIDS Education and Prevention or some other appropriate body approach the Correctional Service of Canada (CSC) and provincial corrections ministries to enter into discussions to develop appropriate policies and procedures for the prevention, education, and care and treatment of Aboriginal offenders with respect to HIV/AIDS.
>
> That the Joint Committee on Aboriginal AIDS Education and Prevention enter into discussions with Aboriginal justice and corrections organizations (e.g. Aboriginal Legal Services of Toronto, Native Clan in Winnipeg, Native Counselling Services of Alberta, Feather Hope in Edmonton etc.) with a view to initiate contact with the Native Brotherhoods and Sisterhoods and other Aboriginal inmates to encourage them to be tested for HIV. Aboriginal Elders could be used in the initiative.
>
> That HIV/AIDS education should be compulsory for all Aboriginal inmates and all staff in correctional institutions.
>
> That the Joint Committee on Aboriginal AIDS Education and Prevention enter into discussions with CSC to coordinate the design and delivery of a comprehensive HIV/AIDS education program to be offered to Aboriginal offenders in prisons in Canada. CSC should contract with an appropriate Aboriginal organization to develop and deliver to [sic] program. The program should be tailored to the special needs of Aboriginal offenders.
>
> That the Joint Committee on Aboriginal AIDS Education and Prevention coordinate the delivery of the HIV/AIDS education program to Aboriginal and non-Aboriginal agencies outside the prison system which deal with Aboriginal offenders (e.g. Friendship Centres, halfway houses, Parole and Probation Offices, Aboriginal Legal Services etc.).
>
> That the Joint Committee on AIDS Education and Prevention, in cooperation with an Aboriginal agency, examine the need for the establishment of special Aboriginal treatment programs and facilities, such as an Aboriginal hospice, in the future.[509]

In Australia, it has been pointed out that three factors exacerbate the risk for Aboriginal offenders of contracting HIV infection in prisons: the overrepresentation of Aboriginals in Australian prisons; the generally low standard of health of Aboriginal prisoners, who have a high prevalence of hepatitis B infection; the inappropriateness of

many HIV/AIDS programs and services, which are designed and delivered for and by white Australians.[510] It has therefore been concluded that in developing educational or prevention programs for Aboriginal offenders, their generally lower health status has to be taken into account.[511] It has further been said that "[m]easures which keep Aboriginal peoples out of prison as well as procedural reforms within the prison systems are vital to avoid increased exposure of Aboriginal peoples to AIDS risks."[512] According to Nangala, the challenges are clear: (1) finding socially acceptable alternatives to imprisonment for Aboriginal people, in particular in relation to minor offences; (2) improving the access Aboriginal people have to health information and educational services in prison; (3) providing educational material that is culturally relevant, particularly in terms of language and general presentation; (4) improving prisoners' access to the means – for example, condoms and clean needles – by which they might protect themselves from HIV/AIDS and other infectious diseases; (5) keeping testing confidential and voluntary, and improving pre- and post-test counselling facilities; (6) ensuring that Aboriginal or Torres Strait Islander people from appropriate health services are used as health educators within prisons to deliver programs to Aboriginal and Torres Strait Islander prisoners; and (7) ensuring that State and Territory Governments and prison administrators consult and liaise with Aboriginal community-based health specialists, so that culturally appropriate approaches to dealing with AIDS are implemented.[513]

With regard to educational programs, Heilpern and Egger suggest that they "need to be tailored to the attitudes, beliefs and practices of the Aboriginal people and be delivered by people, usually Aboriginal, in whom the Aboriginal prisoners have trust and confidence."[514] "The success of such programs is often achieved by negotiating with each community so that audiences, messages and materials are agreed upon and worked out jointly."[515]

An example of the development of programs for Aboriginal inmates is that of the prison of Port Augusta in Australia, where a large proportion of the inmates are Aboriginals. In that prison, drug and alcohol social workers worked with Aboriginal inmates and Elders from their communities. Following negotiations and discussions with the Elders and inmates, a workshop on HIV and Aboriginal communities was held at the prison in conjunction with a local Aboriginal community health centre.[516,[58]]

Without exception, respondents to ECAP's *Working Paper* agreed with the Committee's conclusions relating to education, care and support of Aboriginal inmates. However, the National Advisory Committee on AIDS regretted that the *Working Paper* "does not take a strong position on acquiring information on the interrelationship of HIV, prison and aboriginal prisoners," and missed "a clear, concise and strong recommendation on this subject." NAC-AIDS further suggested that "the collection of both behavioural and prevalence information should largely be directed by the inmates themselves following consultation with appropriate resource personnel." The Native Counselling Services of Alberta emphasized that a support system for Aboriginal inmates infected with HIV should be in place, and that this should include counselling for family members.

ECAP'S ASSESSMENT

In order to learn more about the needs and concerns of Aboriginal inmates, ECAP held a two-day consultation with the Native Sisterhood of the Prison for Women and representatives of the Native Brotherhoods of several nearby penitentiaries. This consultation, which was held in a setting of prayer, drumming, and dancing, included group discussions about the needs and concerns of Aboriginal inmates with regard to HIV/AIDS and drug use. ECAP was impressed by the proposals made at that consultation to address

[58] For more information about the New South Wales Department of Corrective Services' Prison Peer Education Program for Aboriginal inmates, see K. Faulkes. Education on the Inside. [Australian] *National AIDS Bulletin* October 1993:16.

some of their needs and concerns. Among these were a proposal to develop posters that would create AIDS awareness among Aboriginal offenders, and one to develop Aboriginal peer education programs.

ECAP strongly supports such initiatives, by and for Aboriginal inmates, that recognize their special needs and cultural values and promote opportunities for them to improve their health. The proposals presented to ECAP at the consultation at the Prison for Women are examples of this approach. ECAP considered that the following initiatives would encourage and promote greater efforts to address the special problems relating to HIV infection encountered by Aboriginal inmates:

(1) Development of information and prevention programs that will respond to the specific needs of Aboriginal inmates.

(2) Inclusion of community and peer input into these programs. Aboriginal communities and Elders, as well as Aboriginal inmates, should be included in the development, design and implementation of education, prevention, care and healing programs.

(3) Increased efforts, for and by Aboriginal inmates, their communities and Elders, with the assistance of CSC and others, to improve the health status of Aboriginal inmates. This should include providing Aboriginal inmates with access to traditional healers, healing ceremonies, and medicines.

(4) Increased efforts to decrease the vulnerability of Aboriginal inmates to exposure to infectious diseases, in particular HIV infection, to drug use and its harms, and to imprisonment.

ECAP considers that such efforts would be consistent with, and in part are mandated by, sections 79 through 84 of the *Corrections and Conditional Release Act.*

RECOMMENDATIONS

14. ECAP recognizes the special needs and concerns of Aboriginal inmates with regard to HIV infection and AIDS. ECAP recommends that CSC's current efforts to respond to these needs be improved by the following:

(1) CSC should ensure that, in accordance with its policy, Aboriginal inmates have access to traditional healers, healing ceremonies and medicines.

(2) Educational and prevention programs should be developed that will respond to the specific needs of Aboriginal inmates.

(3) Aboriginal groups and Elders/Healers should be encouraged to deliver these programs.

(4) CSC in collaboration with Health Canada and others should fund Aboriginal groups and Elders/Healers to provide this education.

(5) Aboriginal inmates should be encouraged and assisted in developing their own peer education, counselling and support programs.

(6) CSC in collaboration with Health Canada and others should fund such programs.

15. IMPLEMENTATION OF ECAP'S RECOMMENDATIONS

Several of the respondents to ECAP's *Working Paper* have pointed out that the *Working Paper* did not establish a clear mechanism to ensure accountability for the implementation of ECAP's recommendations, and that there is a need for "a strategy outlining implementation and evaluation of the document." ECAP agrees that incorporating such a mechanism into its *Final Report* and recommendations is needed, and considers that the Correctional Service of Canada should establish a mechanism for monitoring and regularly reporting on the implementation of the recommendations in ECAP's Report.

In order to ensure accountability for the implementation of its recommendations, ECAP makes the following, final recommendation:

15. **ECAP recommends that the implementation of its recommendations be reviewed every six months by one or more individuals who are independent of CSC, and that the results of this review be made available to the public.**

CONCLUSION

The Expert Committee on AIDS and Prisons has undertaken an in-depth analysis of 14 major issues raised by HIV infection and by drug use in federal correctional institutions. The Committee believes that responding to each of these issues and to the Committee's recommendations will be necessary if HIV transmission and its adverse consequences in prisons are to be prevented.

Canada has a unique opportunity to act to reduce the harms from HIV/AIDS and from drug use in prisons and to protect the health of inmates, staff and the public. Rates of infection are still relatively low in prisons, particularly when compared with those of many other industrialized countries. Needle exchanges have been established in major Canadian cities at a time when rates of infection among injection drug users were still relatively low. They have been successful in reducing the spread of HIV infection among injection drug users, and in providing them with education and facilitating access to various support services. Injection drug users constitute by far the largest group of infected inmates. By reducing the spread of HIV infection among them, the work of needle exchanges in the community has been one of the major contributors to the prevention of the spread of HIV infection in prisons.

The fact that rates of infection are still relatively low in prisons in Canada does not mean that the measures necessary to prevent further spread of infection can be delayed. On the contrary, it means that steps have to be taken immediately in order to avoid rates of infection reaching the high levels observed in some other prison systems. Any measure undertaken now to prevent the spread of HIV infection will benefit prisoners, staff, and the public.

First, it will protect the health of prisoners. Prisoners are in prison as punishment, and not for punishment. Their human rights must be respected, except for those limitations demonstrably necessitated by the fact of incarceration. In particular, they are entitled to protection from contracting diseases, and governments and prison administrators need to face up to the risks of the spread of HIV infection.

Second, any measure to protect prisoners will also protect staff in correctional institutions. Lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered. Efforts to prevent infection should therefore not be viewed as favouring either inmates or staff, and efforts that protect inmates do not conflict with those that protect staff.

Finally, measures to prevent the spread of HIV infection in prisons also protect the public. Indeed, they are mandated by a sound public health policy. Most inmates are in prison only for relatively short periods of time and are then released into their communities. In order to protect the general population, HIV/AIDS prevention measures need to be available in prisons, as they are outside. Generally, measures undertaken to promote and protect the health of prisoners will promote and protect the health of all Canadians.

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